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Missouri Medicine

Journal of the Missouri State Medical Association
January 1996

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- AMA House of Delegates Actions on the Study of the Federation
- Advanced Directives and the Patient Self-Determination Act

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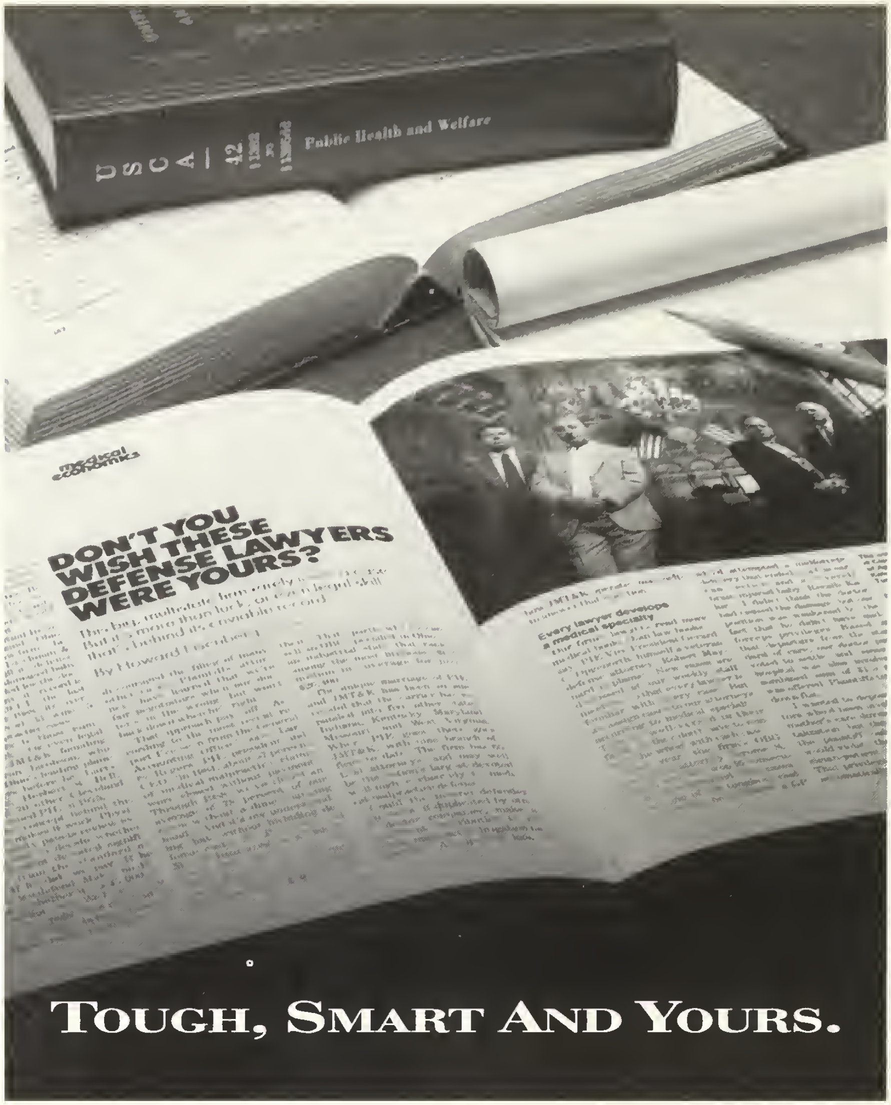
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Owned and edited since 1904 by the Missouri State Medical Association. Missouri Medicine, Journal of the Missouri State Medical Association, [ISSN 0026-6620] is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices.

Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept., P.O. Box 1028, Jefferson City, MO 65102.

The subscription price per year for non-members is $60.00. Annual subscription for members is included in the annual membership dues. Single copies are $8.00 and the per copy cost of the annual August Directory is $40.00.

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MISSOURI MEDICINE

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On the Cover: "Canadas - Spring Thaw" an oil painting by Leland D. Schaperkotter of Columbia, Missouri.

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New Beginnings, Again: Part II

J. Regan Thomas, MD, Editor

It's January again, a time to review the past, plan the future, and begin new beginnings again. In fact, two years ago I titled the editorial, "New Beginnings." Reflections on the past activities of the journal and the state of medicine were discussed. This year it is particularly interesting to remind ourselves of the differences as well as the similarities of the year ago.

Remember the talk about "gridlock" in Congress last year. Many cynically gloated a year ago that the gridlock derailed health system reform measures that they opposed. A year later we don't seem to hear the "gridlock" term mentioned as often. Nevertheless at the time of this writing, the long debated balanced budget doesn't seem to have moved closer than a year ago. In fact, the government closed for a short time in November and now threatens to stop work again into January. Gridlock by any other name still seems as prevalent.

Medicare and health care financing seem just as controversial now as a year ago. Final resolution of the debate must be at hand soon, but again we all thought the same a year ago.

The corporate sector continues to become increasingly involved in medicine. It does seem that there are fewer announcements about hospital mergers and practice "buyouts" than a year ago. Has it finally plateaued or are there simply no more hospitals or practices left to merge? The real impact of these new arrangements is still to be felt. We can be sure that more changes in medical practice will follow.

Medical demographics are continuing to change. More women physicians will change the face of medicine. The numbers of employed continues to grow dramatically. The year to come will begin to define the changes that these demographics will effect.

The AMA now is evaluating changes in the organization of organized medicine. The demographic changes that make up physician relationships to organized medicine have also begun to have an effect. AMA is trying to reflect these changes through reorganization. The specialty organizations are playing a greater role for many physicians and the AMA is trying to respond to evolving methods of representation.

One thing is constant. The need for active physician participation continues to be of tremendous importance. I hope to continue to use this editorial page to urge physicians to use their talents and energies beyond the confines of their individual practices and to interact with the greater community. Challenges will continue to be present during the coming year. *Missouri Medicine* plans to be an active participant in addressing these challenges as we start "New Beginnings, Again: Part II." Happy New Year.

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Lest We Forget

Frederick Hahn, MD, MSMA President

Three and one-half decades ago I started my pathway in medicine as a freshman medical student at the State University of Iowa. As I recall, I had to pay about $385 a semester for tuition at that time. Minimum wages were 75 cents an hour. With two children in diapers and all the other expenses that it took to run a family, I had to borrow from any and all sources available. As I griped verbally about the cost of my education, one of my acquaintances brought a new perspective to my awareness.

This gentleman pointed out that even the citizens of the state of Iowa were investing in me. It cost the state hundreds of thousands of dollars at that "ancient" date. Indeed, the tax payers of the state of Iowa were providing me with an opportunity which I could not have even considered were I to have footed that horrendous tab on my own.

Today, the tuition one must pay to attend one of the least expensive state schools in Missouri is at least 10 times the amount required of me. At the same time, the cost to the citizens of the state of Missouri is well over 10 times what it was in 1960.

I believe that I can safely say, there are no professionals more indebted to their fellow citizens than those of us in medicine. Before we become puffed up with the importance of our individual God-given talents, the majority of us must necessarily remember those who have helped us to achieve our professional goals.

This month the Missouri legislature has convened once more. Again this year, among the most important issues at hand will be the 1996 version of the Patient Fairness Act which will allow patients to make informed decisions in the managed care market. Other issues include a law allowing for better immunization statistics in our state, a bill requiring health plans to provide coverage for a minimum period of time for mothers and their newborns, and many more bills dealing with health care for the citizens of Missouri.

Our fellow citizens have made it possible for us to serve as a professional in THE most trusted profession. Our chance for "pay back" is to speak out in the best interest of our patients - the good citizens of Missouri.

Biblically we are told that "the poor will always be with us." As I have reflected in the past, I always considered that phrase to mean those who had no significant negotiable financial means. As I matured, I have come to wonder if this does not also include those Poor in Manners, Poor in Judgement, and Poor in Ethics. Our fellow citizens have made it possible that we should NOT experience the discomfort of poverty. We alone must be certain that we do not become poor in manners, ethics or judgement.

The best opportunity we will have to voice our professional concern about health care legislation is at the Physician's Day at the Capitol, Tuesday, February 6, 1996. Let's all speak up for what is good first for our patients. This ultimately will be that which is good for us as well. MoMed

Actions of the AMA House of Delegates on the Study of the Federation

A proposal to reduce state medical society representation in the AMA House of Delegates while increasing specialty representation was rejected at a meeting of the House in December.

The Delegates did, however, adopt philosophical statements from the Study of the Federation that may well lead to a restructuring of the House. The Study was prepared during a two-year period by a special task force composed of AMA, state, local, and specialty societies' representatives.

The proposal would have reduced the percentage of state Delegates in the House from the current 79% to 58% over a three-year period. Society representation would have increased from 19% to 34% while the remainder of the Delegates would have been selected from mode of practice, demographic, ethnic, and cultural categories.

The Council of the MSMA had received the Study only a short time prior to the AMA meeting and requested Missouri's Delegates to urge the AMA House to delay action on the Study until the July 1996 meeting. Although MSMA's delegation sought such a delay, the House decided to vote on the 34 recommendations one-by-one.

The AMA House adopted the following recommendations:

■ The Federation of Medicine should be restructured in a way that enables each medical association to retain its individual identity and activities, but which functions more like a total enterprise. The AMA should become the framework within which a new Federation of medicine is established.

■ The restructured Federation of organized medicine should be built on the basic components of the existing Federation: local medical societies/counties, state medical societies, specialty societies and the national umbrella organization (the AMA). Additional components may need to be included.

■ Individual physician membership should remain the predominant form for membership in all components of the Federation.

■ The primary objectives of the new Federation should be: (1) an increase in value of membership; and (2) unity of voice and action of all Federation components.

■ Physicians should be encouraged to join organized medicine at all levels of the restructured Federation. There should be initiatives to encourage maximum collaboration in membership development efforts among components of the Federation.

■ Federation participants must recognize that achieving real unity of voice and action and achieving true enhancement of the value of membership will require significant streamlining of roles throughout the Federation to reduce duplication (i.e., cost and dues) and create synergy.

■ The roles of organizations serving physicians should be clarified and positioned to take full advantage of the strategic advantages enjoyed by each kind of organization. The Federation of organized medicine will be a catalyst and a forum for pursuing collaborative efforts to enhance the value of membership throughout the Federation. This effort will be the highest priority in the implementation process for creating the new Federation.

■ The AMA House of Delegates should be composed of individuals representing organizations that reflect the major dimensions of a physician's life.

■ The Federation House of Delegates should strive to be as inclusive as possible of physician organizations that have a stake in, and a contribution to make to, the goals of the Federation.

■ State societies should be represented by one delegate for every 1,000 AMA members or portion thereof.

■ State societies should continue to count AMA direct members from that state for purposes of determining delegation size.

■ Specialty societies should continue to have representation in the AMA House of Delegates with a delegate allocation formula to be developed for the consideration of the AMA House of Delegates at its 1996 Annual Meeting.

■ The current criteria for specialty society eligibility will continue to apply.

■ State societies should continue to get a "bonus delegate" for being unified. Specialty societies that are unified should also get a "bonus delegate."

■ Consistent with the idea that "voting" is not the only way to participate in an organization, mechanisms should be established through which organizations or groups of physicians with particular interests can meaningfully participate in the Federation without having a vote in the House of Delegates. The AMA Council on Long Range Planning should be asked to identify such mechanisms.

■ Consistent with Section 2.73 of the AMA Bylaws, the Speaker of the House shall establish a special committee of the House to study ways to enhance the election process for positions on the AMA Board of Trustees and to study the size, composition, and terms of service of the AMA Board to enable it to function in the context of the new Federation of Medicine. At a minimum, a progress report on the work of this committee should be presented to the AMA House at its 1996 Annual Meeting. The final report of this committee shall be presented to the House no later than the 1996 Interim Meeting.

■ The AMA Councils, and other governance elements should be analyzed by the Council on Long Range Planning to determine if similar efforts to reflect change should be made in each case.

■ To establish a new, effective Federation of Medicine, a mechanism will be needed for the purposes of:

a. Clarifying roles and achieving active coordination of efforts:
    i) developing a process for helping to coordinate the responses of medical associations to key issues,
    ii) enhancing communication among medical associations and between medical associations and physicians,
b. Establishing a process for pursuing collaborative efforts among federation members:
    i) identifying opportunities, including joint ventures, for medical associations to work together,
    ii) promoting information sharing and compatible database development among medical associations.

■ The current Project Team of the Study of the Federation shall provide a report at the 1996 AMA Annual Meeting that clarifies and provides more detail regarding specialty society representation and representation by major dimensions of a physician's professional life. Further, the Project Team should provide more specific details regarding how the new Federation should be implemented, including transition steps. In pursuing its work between now and the 1996 Annual Meeting, the Project Team should solicit broad input from components of the Federation to determine and assess their attitudes, desires, and intent regarding the principles of the restructured Federation. The report of the Project Team shall be made available to all Federation components well in advance of the 1996 Annual Meeting so that everyone will have the opportunity to review it thoroughly and be able to act on it at the 1996 Annual Meeting.

The House referred the following recommendations back to the Board of Trustees for report to the House in July. The referred recommendations include:

❑ Participation of physicians by the category of mode of practice should be pursued by establishing "forums" that will assess the level of interest among physicians in those categories and develop

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Notice of Redemption of MSMA Subordinated Notes

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The Central Trust Bank

Robert J. Swift, Jr.
Vice President and Trust Officer

AMA House Actions, Continued from page 11

recommendations for a more permanent participation mechanism, possibly including representation in the House of Delegates. The initial "mode of practice" categories for establishing forums should be: 1. solo and small independent practice; 2. small-medium size groups; 3. large groups that are medical groups only; 4. large groups that assume actuarial risk (i.e., managed care); 5. medical teaching; 6. research; 7. administration. Each group could develop a recommended representational approach unique to its particular characteristics and needs. The House would ultimately decide on the acceptability and voting strength of each.

☐ Participation of physicians by demographic/ethnic/cultural characteristic would also be pursued by assessing the level of interest and developing recommendations for more permanent voting or non-voting participation mechanisms.

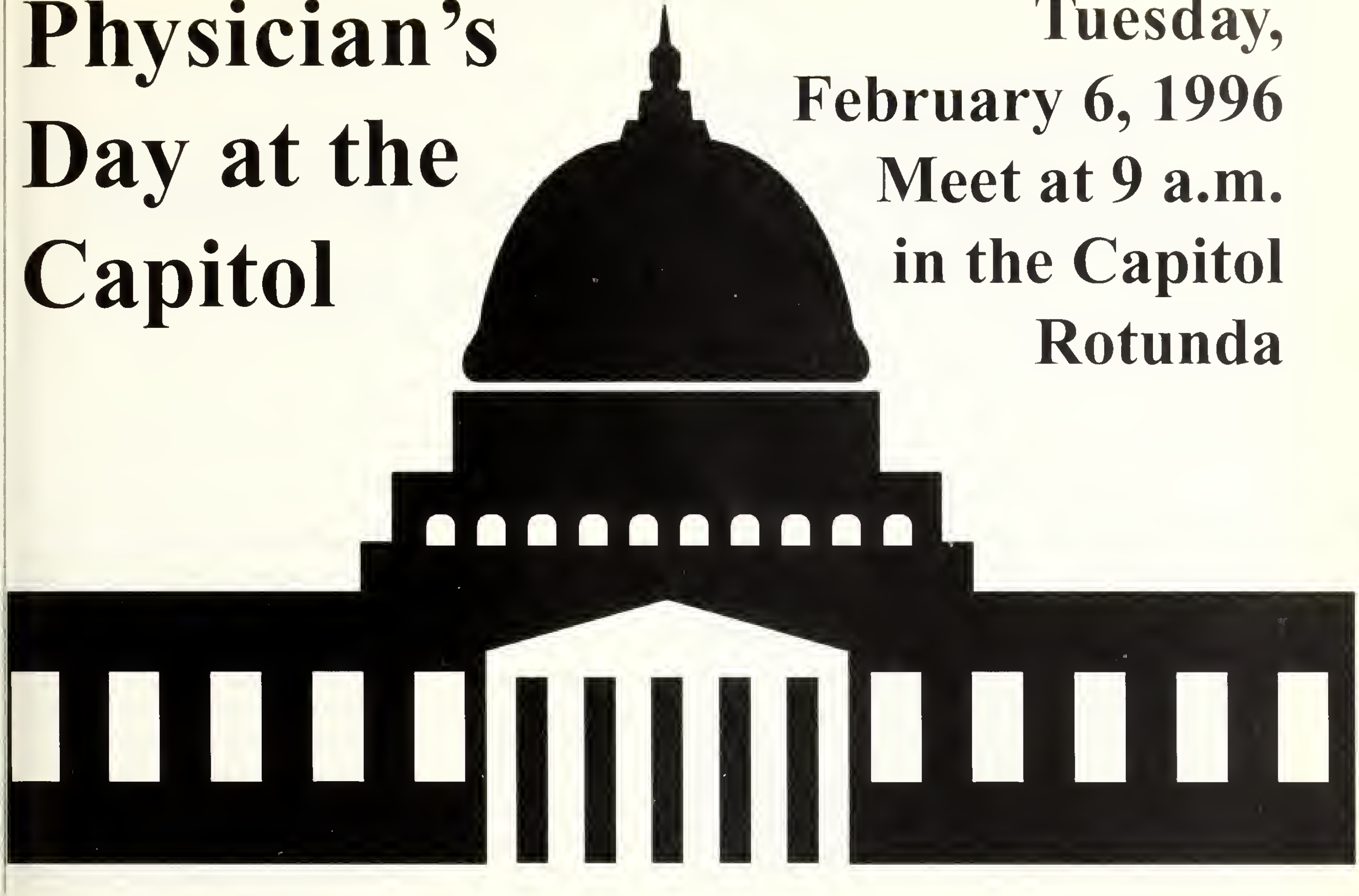
☐ Because of the potentially large number of new groups related to the "mode of practice" and "demographic/ethnic/cultural" categories, they would have to provide their own financial support. Further, it would be expected that any permanent participation or representation mechanisms to emerge from the preliminary analyses would include strategies to make them self-sustaining.

☐ A few groups that already have had a formal presence in the AMA for some time should have the option available to them of being formalized into sections under the current section format, procedures, and financial support arrangements. These include IMG's and women physicians. The Council on Long Range Planning should be asked to explore whether minority physicians should also be considered for such an option.

☐ The following organizations should be offered a voting seat in the House: The National Medical Association, the American Medical Women's Association, and the American Osteopathic Association. The Council on Long Range Planning should develop criteria to use in evaluating whether ethnically-based physician organizations should be considered for representation. MoMed

Physician's Day at the Capitol

Tuesday, February 6, 1996 Meet at 9 a.m. in the Capitol Rotunda



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This is an excellent opportunity for Missouri physicians to speak with one clear voice in the halls of the Capitol.

Advanced Directives and the Patient Self-Determination Act

Gerald M. Sill, JD

There is often confusion among patient care providers concerning the legal principles and statutes governing the use of advance directives and the application of the federal Patient Self-Determination Act. The former concerns the right of individuals to make medical decisions for themselves, including rejection or termination of life sustaining treatment; the latter deals with certain federal requirements to assure that patients are informed about these rights.

In Missouri, much of the legal foundation for use of advance directives can be found in the famous court decisions issued by the Missouri Supreme Court and the United States Supreme Court involving Nancy Cruzan. Nancy Cruzan was the young lady who was in a permanent vegetative state as the result of an automobile accident. The courts were asked to allow life-sustaining treatment in the form of nutrition and hydration to be discontinued. The United States Supreme Court found that Missouri had a standard requiring "clear and convincing" evidence to determine the wishes of an incompetent patient concerning withholding or withdrawing life-sustaining treatment. That is, before withholding or withdrawing life-sustaining treatment, health care decision makers must have clear, persuasive information about what the patient would have wanted had he or she been able to speak to the situation. The United States Supreme Court determined that this standard did not violate the United States Constitution.

The best means for an individual to insure that his or her wishes are honored when incapable of making end of life decisions for themselves is through making a written advance directive. An advance directive is simply a document that can spell out in detail when the advance directive becomes operative and what treatments can and cannot be administered. The two principal forms of advance directive in Missouri are living wills, sometimes referred to as medical directives or health care declarations and durable powers of attorney for health care.

The concept of the living will or medical directive can be confusing under Missouri law. The Missouri General Assembly approved a law in 1985 authorizing the use of a health care "declaration." The statute prescribed a document, which could be used to direct medical care when a person is in a terminal condition and unable to make medical care decisions for themselves. However, the statute clearly prohibited a person from directing the withholding or withdrawal of life-sustaining treatment (referred to in the statute as "life-prolonging" treatment) in the form of nutrition and hydration. The issue of withdrawal of nutrition and hydration was at the heart of the debate over end-of-life treatment decisions during the latter 1980s.

The Cruzan case apparently has provided an alternative in Missouri to utilizing the statutory health care declaration. As previously stated, the U.S. Supreme Court found that Missouri has in place a standard wherein action can be taken with respect to withholding or withdrawing life-sustaining treatment (which would include provision of nutrition and hydration) based upon clear and convincing evidence of an individual's wishes and desires. Therefore, it follows that as a matter of common law principle (principles generally stated by the courts), a person could create a living will directing medical care decisions including withholding or withdrawing nutrition and hydration.

In 1993, the Missouri General Assembly authorized an additional type of directive - the durable power of attorney for health care. Using this document, a person can appoint someone, called an attorney-in-fact, to make virtually all health care decisions for him or herself. A person may also specifically authorize the attorney-in-fact to withhold or withdraw nutrition and hydration. The durable power of attorney for health care can be used as the sole document for purposes of health care decision making on behalf of a person unable to make these decisions or it can be used in conjunction with a living will or health care declaration.

The role of the Patient Self-Determination Act in allowing for a mechanism for patients to express their health care treatment wishes through advance directives is frequently misunderstood. This law is a federal statute enacted in 1990 designed to encourage the use of advance directives. The law does not mandate the use of advance directives, nor does it speak to the substance of advance directives.

The Patient Self-Determination Act (Act) simply requires that certain information about advance directives be provided to patients of certain health care institutional providers that contract with Medicare and Medicaid, the federal health programs for the elderly and the poor, including hospitals, home health agencies, hospices and skilled nursing facilities. The Act requires that any patient entering into or receiving initial services from a designated Medicare and Medicaid institutional provider be given information about their right to be informed of and consent to medical procedures and their right to make advance directives under state law. The Act also requires the health care provider to explain whether it will honor an advance directive. (The provider is not required by this law to honor advance directives.) Finally, the Act requires the health care provider to ascertain whether the patient has an advance directive. The Act does not require the patient to execute an advance directive. However, the Act does require the health care provider to provide services regardless of whether the patient had an advance directive or not.

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Advance directives are an important device for individuals to consider in planning for their health care needs. Their use should not be confined only to the elderly, but should be carefully considered by everyone. The advances in medical technology are occurring so rapidly that the concepts of what can be done medically is often beyond a person's ability to imagine. Advance directives allow a person to think ahead and provide individually tailored instructions.

The Author

Gerald M. Sill, JD, is Senior Vice President and General Counsel for the Missouri Hospital Association, an organization with which he has been associated since 1981. He is also an adjunct professor teaching health care law for the Program in Health Services Administration at the University of Missouri-Columbia.

Membership Notes

Keith A. LaFerriere, MD

Keith A. LaFerriere, MD, a facial plastic surgeon and member of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), from Springfield, Missouri, was elected to the office of Midwest Regional Vice President at the Academy's annual Fall meeting held in New Orleans. Dr. LaFerriere will coordinate the continuing medical education, membership, and fellowship programs of the Educational Foundation of the AAFPRS within the Midwest region and serve as a member of the Board of Directors for a term of three years.

Samuel B. Guze, MD, Spencer T. Olin Professor and Head of the Department of Psychiatry at Washington University School of Medicine, has received the fourth annual Rhoda and Bernard Sarnat Prize in Mental Health. The Sarnat Prize recognizes individuals, groups or organizations for outstanding achievement in improving mental health. In particular, the award was created to spotlight contributions that improve the understanding of or treatment for mental disorders, innovations in mental health services and public policy changes that improve mental health services. The prize is given by the National Academy of Science's Institute of Medicine. Dr. Guze was selected for the prize because of his pioneering work in the diagnosis of psychiatric disorders. He was part of a group at Washington University that created a scientific model and introduced a biological approach to the diagnosis and treatment of mental illness. The idea was to diagnosis and treat psychiatric patients in the same way that other physicians approach patients with physical illness. They helped to create the "American Psychiatric Association's DSM-III" (Diagnostic and Statistical Manual of Mental Disorders) which was first published in 1980. Dr. Guze's work over the past three decades has helped lead to a return to the medical roots of clinical psychiatry. His research has also spawned great interest in the genetics of psychiatric disorders. His work as resulted in widespread recognition of the importance of epidemiological understanding and knowledge concerning mental illness. His research contributed key knowledge regarding genetic vulnerability to alcoholism as well as other conditions including schizophrenia and affective disorder.

Ronald J. Chod, MD, has been named assistant dean for clinical affairs at Washington University School of Medicine. Dr. Chod comes to the school from BJC Health System, where he was vice president of clinical affairs. Prior to that, he practiced obstetrics and gynecology in the St. Louis area. In his new role, Dr. Chod will help foster partnerships between the School of Medicine faculty and community physicians. He also will assist in the development of clinical services and programs at Washington University Medical Center.

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine,*** *113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

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AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

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Peter C. Boylan, *Kansas City*
Alan L. Braun, *Jefferson City*
Alton D. Brookreson, *Poplar Bluff*
Richard D. Bucholz, *St. Louis*
Francis H. Corcoran, *Joplin*
James R. Criscione, *St. Louis*
Edward W. Czebrinkski, *Chesterfield*
Ananda DeSilva, *Hazelwood*
Rengachary Dhanalakshmi, *Kansas City*
Michael D. Dunlap, *St. Joseph*
John R. Fitz, *Farmington*
Marvin L. Fowler, *West Plains*
Charles P. Gauthier, *Kansas City*
Sangwill L. Gernstetter, *Poplar Bluff*
William H. Gondring, *St. Joseph*
James D. Grable, *Cape Girardeau*
Jack Hartstein, *Chesterfield*
Patrick A. Hogan, *St. Louis*
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Patricio H. Mujica, *St. Joseph*
David M. Near, *St. Louis*
Alejandro C. Ojascastro, *St. Louis*
Carlton S. Pearse, *Chesterfield*
Kenneth D. Piker, *Springfield*
William H. Poggemeier, *St. Charles*
Earl L. Rapp, *Hannibal*
Abbiah N. Reddy, *Poplar Bluff*
Lisa Brodsky Ring, *Bridgeton*
Gregory C. Rinehart, *St. Louis*
Howard H. Roberts, *Joplin*
Herbert E. Rosenbaum, *St. Louis*
Marvin R. Rush, *Ste. Genevieve*
Wolfgang P. Schuessler, *St. Louis*
Michael R. Scott, *Springfield*
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Thanjavur Med Col University Madras,
Thanjavur, India; 1976

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University of Kansas; 1986

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Matthew G. Moore
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Virginia Price
Kristin Ratliff
Neal K. Sikka
Shawn Stanley
JenniferTaniguchi
Benjamin W. Verdine

In Memoriam

Keith H. Averill, MD, 66, Mission Hills, Kansas, died December 2, 1995. Dr. Averill received his medical degree at the University of Michigan in 1955. He took an internship at Philadelphia General Hospital and then spent three years in the Air Force, receiving the Air Force Commendation Medal for service in Medicine. Dr. Averill as a Flight Surgeon at Randolph Air Force Base, practiced clinical medicine, and researched at the School of Aviation Medicine. He published numerous articles on "Electrocardiographic Findings" and other related topics. Dr. Averill subsequently spent two years in internal medicine at the University of Michigan, and received the Pauline Albert Award for service to the hospital. He then held a two-year fellowship in cardiology at the University of Colorado. Dr. Averill published more articles and received the Mead-Johnson Scholarship Award for research in cardiology. He moved to Kansas City in 1963 and started the cardiology department at Research Hospital, where he designed the first and second catheterization laboratories. Along with the Dr. Hughes Day, he developed the first coronary care unit in the country at Bethany Hospital. He then established the second coronary care unit in the country at Research Hospital. He traveled nationwide to set up coronary care units and catheterization laboratories, initiated the "Code Blue" concept, and devised the "crash carts" used for Code Blues. Dr. Averill taught a six-week cardiovascular Nursing Program beginning in 1967, to train ICU nurses throughout the country. He also lectured to physicians, hospital boards, and medical societies throughout the country about coronary care units and his particular research and experience in the field of cardiovascular disease. He was an Associate of the American College of Physicians, certified by the American Board of Internal Medicine, the American College of Cardiology, and the American College of Chest Physicians. He was elected to Phi Beta Kappa and Phi Kappa Phi at the University of Michigan, and joined Phi Rho Sigma in medical school. Dr. Averill was a member of the American Medical Association, the Kansas City Heart Association, the Missouri Heart Association, and the Missouri Heart Association Research Committee, the American Heart Association, the Council on Basic Science, the Council on Clinical Cardiology, the Council on Rheumatic Fever and Congenital Heart Disease, the Metropolitan Medical Society of Greater Kansas City, Greater Kansas City Society of Internists, the Kansas City Southwest Clinical Society, the American College of Chest Physicians and the American College of Cardiology. Dr. Averill was in private practice from 1963 to 1987. During that time, he was the President of the Kansas City Heart Association (1967), Director of the cardiovascular department at Research Hospital (1963-1976), Clinical Assistant Professor of Internal Medicine at UMKC, Instructor of Medicine at the University of Kansas Medical Center, Consultant in Cardiology at Bethany, Children's Mercy, and Baptist Memorial hospitals, Governor for the State of Missouri for the American College of Cardiology, Director of the cardiovascular department (1967-1987) and President of the Medical Staff (1980) St. Joseph Hospital.

Paul W. Hayes, MD, 84, St. Joseph, Missouri, died November 27, 1995. Dr. Hayes received his medical degree at the University of Nebraska in 1936. He specialized in neurology and psychiatry for 15 years at the former Thompson-Brumm-Knepper Clinic and at the St. Joseph State Hospital for five years. He retired in 1981. Dr. Hayes served with the Army during World War II and the Korean War, retiring as a colonel. He was a member of the Buchanan County Medical Society, the Missouri State and American Medical Associations, American Physicians Association and the American Psychiatric Association.

Randall P. Kuntze, MD, 43, Paragould, Arkansas, died November 14, 1995. Dr. Kuntze received his medical degree at the University of Missouri-Columbia in 1977. He had a rotating internship in OB-GYN at Tulane University Hospitals from 1977 to 1978, and had a residency in anesthesiology from 1988 to 1991 at the University Hospital in Columbia, Missouri. Dr. Kuntze was a veteran of the Navy and served as a lieutenant commander of the Naval Reserve, where he worked as an anesthesiologist. He received a diploma from the American Board of Anesthesiology in 1992. He was the attending physician in family practice from 1978 to 1988 at Twin Rivers Regional Medical Center in Kennett, Missouri. He had worked since 1991 as the attending physician in anesthesiology at St. Francis Hospital in Memphis, Tennessee.

The Patient Fairness Act

Medicine's Highest Priority

With the help of countless member physicians across the state, MSMA came very close to passing the Patient Fairness Act in 1995. To prevent that from happening again in 1996, the insurance and business lobbies have amassed a large war chest to use in fighting MSMA in the halls of the Capitol.

Knowing that we face a major struggle in 1996, MSMA spent much of the summer and fall meeting with other providers and consumer groups to broaden support for our package. The bill was fine-tuned, several important lobby groups have allied themselves with us, and the battle has been joined.

THIS IS WHERE YOU COME IN! If we are to succeed, we need the help and assistance of all Missouri physicians. In this edition we have published the Patient Fairness Act in its entirety as well as a plain-English summary. We need you to offer your voice:

☐ Write or call your state senators and representatives. This is not difficult or time-consuming. We have provided a sample letter for you to use as a model.

☐ Write a letter to the editor of your local newspaper. Several important consumer/patient advocate groups are supporting the Patient Fairness Act. A letter published in your local newspaper may spur your patients into writing their lawmakers.

☐ Talk to your patients about the Patient Fairness Act. This is, after all, designed with them in mind. MSMA has a patient-oriented brochure available explaining the bill and inviting them to participate in the political process.

☐ Attend Physician's Day at the Capitol, a physician rally scheduled for Tuesday, February 6. More details are available on page 13.

☐ Get involved in the political process. 1996 is an election year and most politicians already are running hard. Take the time to participate in a local campaign. Offer to attend or sponsor a fundraiser or some other campaign event. Contribute to candidates you believe have been or will be receptive to the voice of medicine. Let your office-holders and other candidates know that you are a part of the process and that you are available to offer advice on health care issues. These activities are not especially difficult, and we believe you will find them entertaining and rewarding.

The future of the Patient Fairness Act and all other health care issues is in your hands. All your opponents need is for you to do nothing. Please make 1996 the year you decided to get involved.

After MSMA came so close to passing the Patient Fairness Act last year, the insurance industry has launced an massive campaign to defeat us this year. If we are to be successful, we will need grassroots support from physicians and patients across the state.

One thing we ask is that you consider writing the editors of your local newspapers. The letter on the next page is a sample you may use in drafting your personal letter. It is preferable that you not copy this letter verbatim, but use it as a model. Your own words based on your personal experience are much better.

Dear Editor:

As an advocate for my many patients, I am writing to make readers aware of an important piece of legislation being considered in the State Capitol. Senate Bill 641 and House Bill ____ (un-numbered at press time), also known as "The Patient Fairness Act," would establish new requirements for HMO's and other managed care insurance plans. These requirements are designed to ensure that patients are provided with adequate information to make informed choices regarding their health care coverage.

All too often it is nearly impossible to understand just what services are covered, what deductibles and copayments are required, and what limitations are imposed on choice of provider, referrals, and treatment options. The Patient Fairness Act would require plain-English disclosures and explanations for the patient prior to his or her time of need.

The Patient Fairness Act would create reasonable and important safeguards to ensure that patients and their physicians - not insurance companies - control the care patients receive. I believe my patients are entitled to nothing less.

I encourage every one to write Senator ______ and Representative ______ and ask them to support these bills.

PATIENT FAIRNESS ACT HIGHLIGHTS

✓ **All prospective enrollees must be provided truthful, plain-English explanations of a plan's exclusions, limitations, copayments and coinsurance, any hidden out-of-pocket expenses, and any limitations on choice of provider, referrals, or treatment options.**

✓ **Insurers must disclose prior authorization or other review requirements, and must provide enrollee satisfaction information.**

✓ **Insurers must provide adequate access to health care providers, and must meet adequate financial reserve requirements.**

✓ **Health care providers must have input into a health plan's medical policies.**

✓ **All plans must credential their own providers and shall allow all providers within their service area who are licensed to provide covered services to apply for credentialing. The credentialing standards must be made available to all applicants, and the plan's credentialing body must have appropriate representation of the applicant's specialty.**

✓ **All credentialing decisions shall be made on the record, and the applicant shall be provided with all reasons used if an application is denied or a contract not renewed.**

✓ **Plans shall not terminate a contract without giving an explanation, and a due process appeal mechanism shall be established to consider adverse decisions.**

✓ **Prior to a termination of a contract, the provider shall be given an opportunity for discussion and an opportunity to enter into a corrective action plan.**

✓ **Any plan that limits access to providers must also offer enrollees a point of service option. Premiums for that option must reflect the actuarial value of such coverage, and copayments for out-of-network services must be greater than 20 percent.**

Contacting Your Legislators

When considering various legislative proposals, lawmakers want to know the views of their constituents. They are always impressed when a physician takes the time away from a busy schedule to call upon them.

No one knows more about health care than physicians. Legislators want to know your opinion, so tell them your thoughts.

Before you contact legislators let MSMA lobbyists brief you on the status of legislation. Your visit will be more effective with complete knowledge of the status of particular bills.

You may want to visit your legislators in Jefferson City. Make an appointment to meet with them, or perhaps offer to take them to lunch or dinner.

Their time is often limited, so let them know if you want to discuss a complicated subject matter that would take more time than a brief visit. Be sure to thank them for their time.

Stay in touch with your legislators. Let them know your interest is sincere and that they can contact you if they need more information on a medical issue.

Please write to your senators and representatives in Jefferson City expressing your support for the Patient Fairness Act. A listing of State Senators and Representatives and a map of Legislative Districts is provided on pages 31-36.

Below is a sample letter to use as a model. In your letter, please feel free to draw on personal experiences that demonstrate the need for this bill.

Honorable __________
Missouri Senate
Senate Post Office
Jefferson City, MO 65101

OR

Honorable __________
Missouri House of Representatives
House Post Office
Jefferson City, MO 65101

Dear Senator or Representative _____________:

As an advocate for my patients, I am writing to encourage you to support Senate Bill 641 and House Bill _____, the "Patient Fairness Act."

This bill would establish first-ever certification requirements for managed care plans that are designed to ensure that patients are provided with adequate information to make informed choices regarding their health care coverage. All too often it is nearly impossible to understand just what services are covered, what coinsurance and copayments are expected, and what limitations are imposed on choice of provider, referrals, or treatment options. The Patient Fairness Act will require plain-English disclosures and explanations for the patient prior to his or her time of need.

The insurance industry is attempting to portray the Patient Fairness Act as an "Any Willing Provider" bill. It is not. This bill does not require the insurer to accept the application of any willing provider. The bill does, however, create reasonable and important safeguards to ensure that patients and their physicians - not insurance companies - control the care patients receive.

Patients are entitled to adequate information concerning the policies that affect coverage and payment for health care services, and physicians, as patient advocates, must have a voice in the medical decision-making process. The Patient Fairness Act guarantees both.

Please support SB 641 and HB ____, the Patient Fairness Act.

Sincerely,

SECOND REGULAR SESSION

SENATE BILL NO. 641

88TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCOTT

Pre-filed December 15, 1995, and 1,000 copies ordered printed

TERRY L SPIELER, Secretary.

S2494 01I

AN ACT

Relating to health insurance.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section 1. Nothing in this act shall be construed as an "any willing provider" provision, meaning an act that requires any managed care plan to accept the application of any provider willing to abide by the terms and conditions of that plan's contract.

Section 2. As used in this act, the following terms mean:

(1) "Director", the director of the department of insurance;

(2) "Health care provider", any state-licensed or state-recognized provider of health care services or supplies, including, but not limited to, a physician, hospital, dentist, laboratory, pharmacy, pharmacist, podiatrist, psychologist, chiropractor, optometrist, nurse, hospice, or home health agency;

(3) "Managed care contractor", a person who:

(a) Establishes, operates or maintains a network of participating providers; and

(b) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan;

(4) "Managed care entity", a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, provider groups or a managed care contractor

that operates a managed care plan;

(5) "Managed care plan", a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; and

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(6) "Participating provider", any health care provider that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan;

(7) "Qualified managed care plan", a managed care plan that the director certifies, upon application by the program, as meeting the requirements of this act.

Section 3. Nothing in this act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services with that individual's own funds, whether such services are covered within the individual's benefit package or from another health care provider or plan;

(2) Employers from providing coverage for benefits in addition to the managed care plan's benefit package.

Section 4. 1. The director shall establish a process for certification of managed care plans meeting the requirements of this section. The director shall establish procedures for the periodic review and recertification of qualified managed care plans. The director shall terminate or suspend the certification of a previously qualified managed care plan if the director determines that such plan no longer meets the applicable requirements for certification. Before effecting a termination or suspension, the director shall provide the plan notice and opportunity for a hearing on the proposed action.

2. An eligible organization, as defined in section 1876(b) of the Social Security Act, shall be deemed to meet the requirements of

subsection 4 of this section for certification as a qualified managed care plan.

3. If the director finds that a national accreditation body establishes requirements for accreditation of a managed care plan that are at least equivalent to requirements established under subsection 4 of this section, the director may, to the extent appropriate, treat a managed care plan thus accredited as meeting the requirements of subsection 4 of this section.

4. The director shall establish standards for the certification of qualified managed care plans that conduct business in this state, including standards whereby:

(1) Prospective enrollees in managed care plans shall be provided information as to the terms and conditions of the plan so that they can make informed decisions about accepting a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful, and objective terms shall be used. All written plan descriptions shall be in a readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. This format shall be standardized so that customers can compare the attributes of the plans. Specific items that shall be included are:

(a) Coverage provisions, including amount, duration, and scope of coverage, benefits, and any exclusions of health care services by category of service, health care provider, and if applicable, by specific service;

(b) Any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(c) Financial arrangements or contractual provisions with review companies or any other health care provider that would limit the services offered, restrict referral or treatment options, or negatively affect the health care provider's fiduciary responsibility to patients, including but not limited to financial incentives not to provide medical or other services;

(d) Explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other non-covered or out-of-plan services;

(e) Loss ratios;

(f) Enrollee satisfaction statistics, including re-enrollment statistics, reasons for leaving the plan, and the number of complaints filed against the plan; and

(g) Explanation of the internal complaint resolution process maintained by the plan as required by section 354.445, RSMo;

(2) Plans shall demonstrate that they have adequate access to health care providers so that all covered health care services will be provided in a timely fashion. This requirement cannot be waived and shall be met in all areas where the plan has enrollees, including rural areas;

(3) Plans shall meet financial reserve requirements that are established to assure proper payment for covered services provided;

(4) All plans shall be required to establish a mechanism, with defined rights, under which appropriate participating providers in the plan provide input into the plan's medical policy, including coverage of new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria, and health care management procedures;

(5) All plans shall be required to credential health care providers to deliver those health services offered by the plan, and the plan shall not discriminate against any class of health care provider on the basis of licensure. In credentialing health care providers, the plan shall allow all providers within the plan's geographic service area, whose scope of licensure authorizes the delivery of such covered services, to apply for such credentials. However, nothing in this act shall require a plan to accept any health care provider as a participating provider in the plan. The credentialing process shall begin upon application of a health care provider to the plan for inclusion. Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant's specialty and class of health care provider. Credentialing shall be based on objective standards of quality

established with input from health care providers credentialed in the plan, and such standards shall be made available to applicants and enrollees. When economic considerations are part of the decision, objective criteria shall be used and shall be made available to applicants, participating providers and enrollees. Any economic profiling of health care providers shall be adjusted to recognize case mix, severity of illness, age of patients and other features of a health care provider's practice that may account for higher than or lower than expected costs. Profiles shall be made available to those so profiled. When graduate medical education is a consideration in credentialing, equal recognition shall be given to training programs accredited by the Accrediting Council of Graduate Medical Education and by the American Osteopathic Association. Plans shall be prohibited from discriminating against enrollees because of an enrollee's health or medical condition. Plans shall also be prohibited from discriminating against health care providers because their practices contain a substantial number of such patients. All decisions shall be made on the record, and the health care provider shall be provided with all reasons used if an application is denied. A plan's decision to deny an application shall not be subject to the appeals processes set out in this act.

5. There shall be a due process appeal from all decisions to terminate or not renew a contract. The director shall establish a due process appeal mechanism based on the appeals process set forth in the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 to 11152.

6. The same standards and procedures used for an application for credentials shall also be used in the cases where the plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to a termination of a contract for cause, the health care provider shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state licensing board or other government agency that effectively impairs the health care provider's ability to practice his or her profession within the jurisdiction.

7. An enrollee or participating provider who has been aggrieved

by any decision of a managed care entity shall, upon request, be provided a written statement of the reasons for the decision.

8. Procedures shall be established to ensure that all federal and state laws designed to protect the confidentiality of provider and individual medical records are followed.

9. Standards shall first be established under this section by not later than twelve months after the date of the effective date of this section. In developing standards under this section, the director shall:

(1) Review standards in use by national private accreditation organizations and the National Association of Insurance Commissioners;

(2) Recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans; and

(3) Establish procedures for the timely consideration of applications for certification by managed care plans.

10. The director shall periodically review the standards established under this section, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans.

11. Nothing in this act shall be deemed to give rise to a cause of action by any party.

Section 5. No rule or portion of a rule promulgated under the authority of this act shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

Section 6. 1. Any managed care entity that offers a plan that restricts access to providers or controls utilization shall offer to all eligible enrollees the opportunity to obtain from the plan coverage for out-of-network services through a point of service option, as defined by subsection 2 of this section, at the time of enrollment and at least for a continuous one-month period annually thereafter.

2. For the purposes of this act, a point of service option means a plan that provides additional coverage and/or access to non-network providers to an eligible enrollee when the plan restricts access to items and services provided by a health care provider who is not a member of the plan's provider network, or that may cover any other services the

enrollee seeks, whether such covered services are provided in or outside of the enrollee's plan.

3. For the purposes of this section, a provider network means those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide services to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

4. A plan may charge an enrollee who opts to obtain point of service coverage an alternative premium that reflects no more than the actuarial value of such coverage.

5. A point of service option may require payment of coinsurance for an out-of-network item or service with the applicable coinsurance percentage to be based on the plan's actual payment for items or services and to not be greater than twenty percent of that actual payment.

Section 7. All managed care entities shall be in compliance with the provisions of this act by January 1, 1998.

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Major Provisions of MSMA'S Proposed Insurance Market Reform Bill

Due to the length of the Insurance Market Reform Bill, the compelete bill is not printed. The following are highlights of this legislation.

Individual Policies

The Small Employer Health Insurance Availability Act was enacted several years ago to regulate insurers who provide coverage for small businesses (those with no more than 25 employees). MSMA proposes to make individual policies a part of this act and to add a number of new regulatory standards. Among those standards are:

Modified Community Rating

MSMA proposes that all new and renewal premium rates be based on a community rate. All individuals and small businesses (any business with more than three and less than 500 employees) within a given community will pay the same premium for the same health benefit plan, except that the rate can be adjusted according to the policy holder's age and family size. Any adjustment made for age cannot vary by more than 50% above or below the community rate. For rating purposes, there will be five market service areas or "communities": St. Louis, Kansas City, and three areas of equal population drawn from the remainder of the state.

Standard Benefits Packages

The Governor will appoint a 14-member "Health Benefit Plan Committee" (containing at least two physicians) which shall establish five standard benefits packages. All insurers will be required to offer at least one of these plans, and the minimum plan that can be offered must contain all of the HMO benefits provided in the Missouri plan for state employees (a fairly generous plan). One of the standard plans must offer a point of service option which cannot require an enrollee copayment of greater than 20% of the amount which would have been paid for an in-network service if the enrollee seeks out-of-network services.

The bill calls on the Departments of Insurance and Revenue to develop a plan which permits health care services to be purchased using a medical savings account or other such plan with tax incentives.

Open Enrollment

In each "community" there shall be a common annual thirty-day open enrollment period during which each insurer must actively market its plans to all individuals and small employers within its market service area. Open enrollment need not be offered to individuals who have not resided in this state for at least one year.

Pre-Existing Condition Exclusions

No insurer may impose upon an enrollee a limitation or exclusion of benefits relating to treatment of a pre-existing condition. To prevent border crossing and to dissuade individuals from waiting until they are ill to purchase insurance, an insurer may impose exclusions or limitations based on pre-existing conditions for up to six months on individuals who are late enrollees.

Portability

As long as a policy holder pays the premiums, he or she always will have coverage. A health benefits policy can only be terminated for nonpayment of premiums or fraud or misrepresentation.

Risk Adjustment

The Missouri Small Employer Health Reinsurance Board, which exists now to ensure the solvency of insurers offering policies to small businesses, will be charged with establishing efficiency and risk management standards for all health insurers. The Board will reinsure insurers who take on a disproportionate share of high risk enrollees, and subsidize any insurer whose average cost of insuring individuals exceeds the regional average cost by greater than 20%. This encourages insurers to compete in market areas with greater than average risk.

Missouri Senate - 88th General Assembly Second Regular Session

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Kinder, Peter	**27**	635 NW End Blvd., Cape Girardeau, MO 63701; 314/335-6611	**751-2455**	**431**
Klarich, David	**26**	34 Roland Ave., Ballwin, MO 63021; 314/230-8116	**751-1073**	**226**
Lybyer, Mike	**16**	HCR 9, Box 200, Huggins, MO 65484; 417/967-3227	**751-2601**	**333**
Mathewson, James L.	**21**	142 South Limit, Sedalia, MO 65301-3655; 816/826-7815	**751-4771**	**326**
Maxwell, Joe	**18**	#5 Terrace Circle, Mexico, MO 65262	**751-4200**	**329**
McKenna, William P.	**22**	6969 Dippel Lane, Barnhart, MO 63012; 314/464-5684	**751-2504**	**321**
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Moseley, Joe	**19**	3209 Wood Dale, Columbia, MO 65203; 314/874-9555	**751-2131**	**323**
Mueller, Walt	**15**	12325 Manchester Rd., St. Louis, MO 63131; 314/966-2526	**751-3838**	**330**
Quick, Edward E.	**17**	13004 A. Highway, Liberty, MO 64068; 816/454-1078	**751-4524**	**331A**
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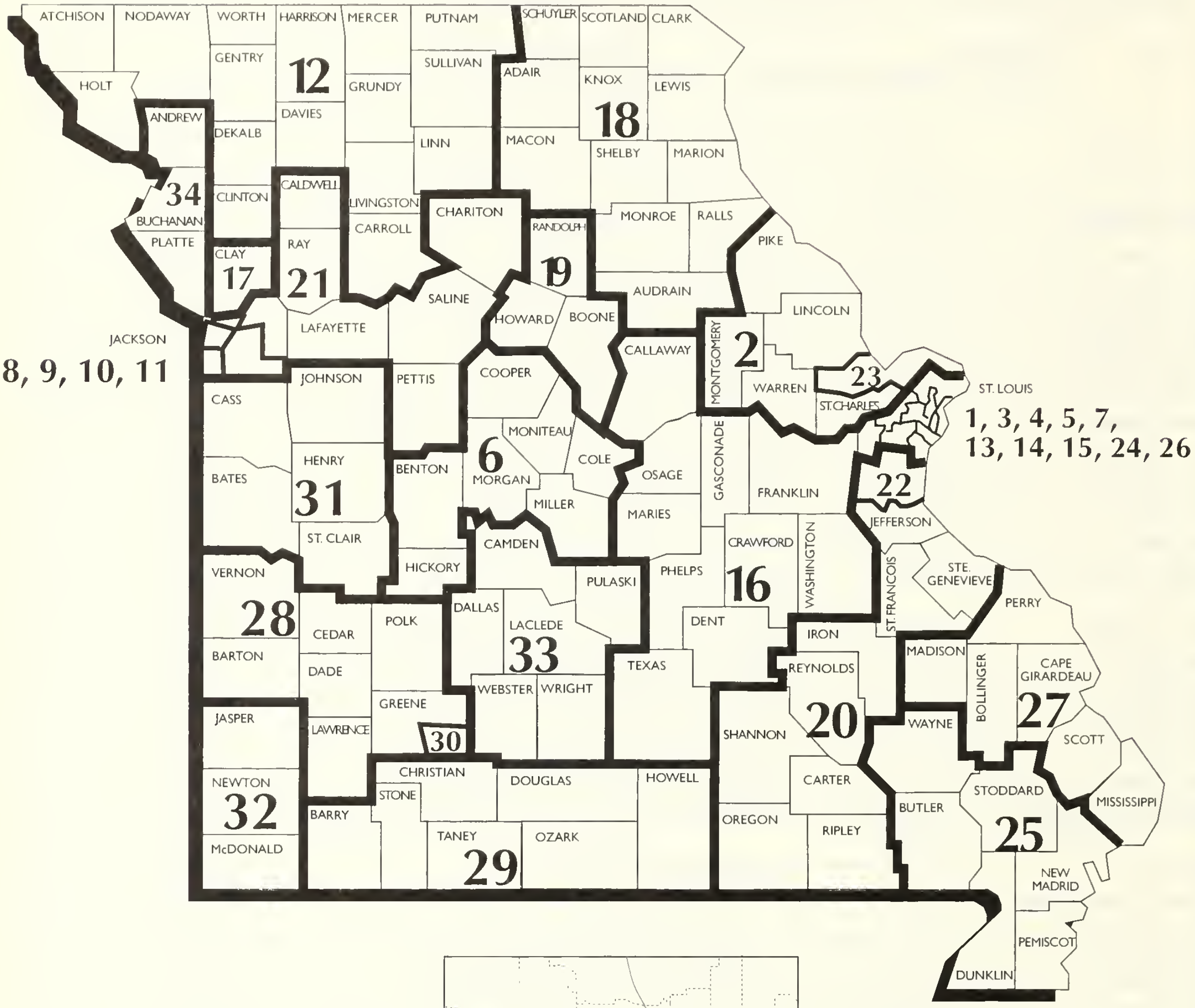
Schneider, John D.	**14**	3520 Tremont Dr., Florrisant, MO 63033; 314/421-2762	**751-4106**	**422**
Scott, John E.	**3**	3761 Bates, St. Louis, MO 63116; 314/481-6864	**751-3644**	**416**
Sims, Betty	**24**	18 Ladue Manor, St. Louis, MO 63124; 314/994-0793	**751-7147**	**425**
Singleton, Marvin	**32**	3401 McIntosh Circle, Joplin, MO 64804; 417/781-2040	**751-2306**	**426**
Staples, Danny	**20**	HCR 3, Box 18, Eminence, MO 65466; 314/756-5592	**751-3534**	**418**
Treppler, Irene	**1**	4681 Fuchs Rd., Mattese, MO 63128; 314/487-1420	**751-2887**	**433**
Westfall, Morris	**28**	RR 2, Box 180 HWAY, Halfway, MO 65663; 417/445-2220	**751-7514**	**220**
Wiggins, Harry	**10**	7817 Terrace, Kansas City, MO 64114; 816/444-5718	**751-2788**	**423**

Missouri Senate Districts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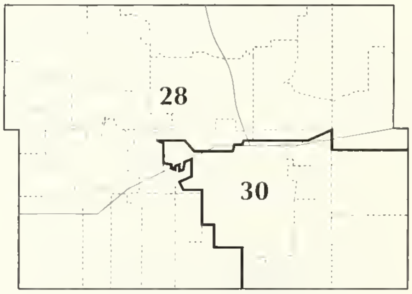

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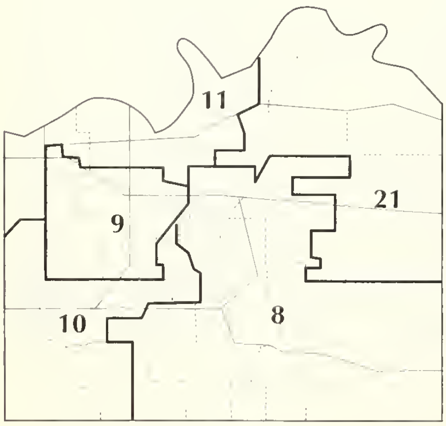

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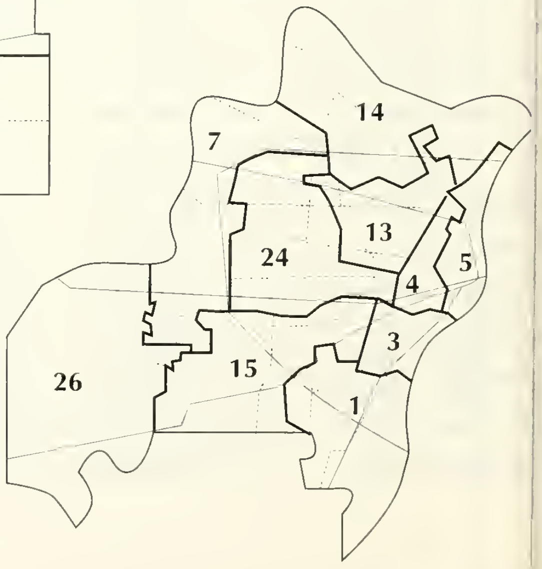
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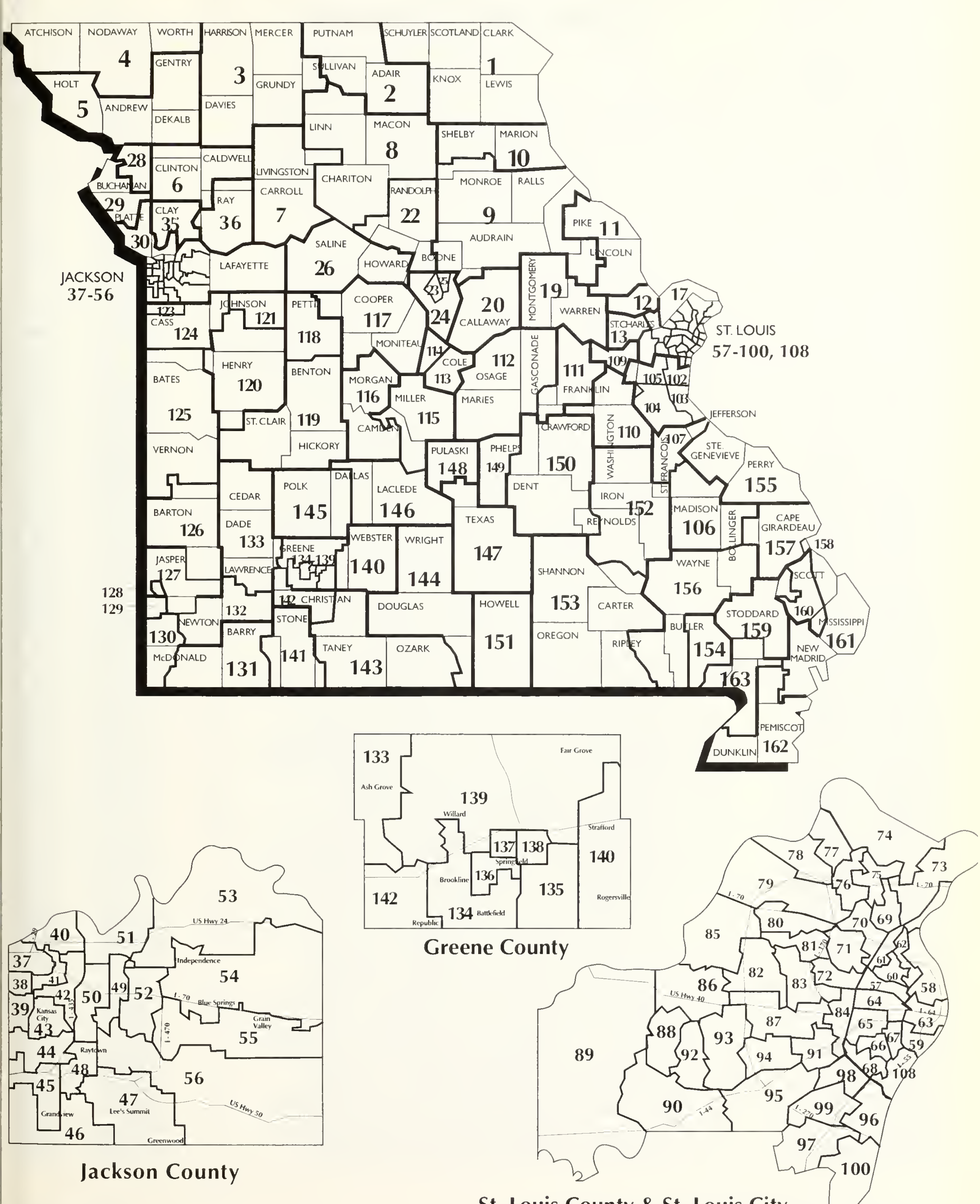
St. Louis County & St. Louis City

Missouri House Districts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Greene County

Jackson County

St. Louis County & St. Louis City

Missouri House of Representatives - 88th General Assembly
Second Regular Session

REPRESENTATIVES	DISTRICT	ADDRESS & PHONE NO.		ROOM
Akin, W. Todd	**86**	305 Conway Hill Rd., St. Louis, MO 63141; 314/542-2116	**751-1186**	**115E**
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Backer, Gracia Y.	**20**	2859 Rt. TT, New Bloomfield, MO 65063; 314/295-6190	**751-2070**	**303A**
Ballard, Charles	**140**	Rt. 4, Box 3450, Marshfield, MO 65706; 417/859-6454	**751-9809**	**135BB**
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Barnett, Rex	**4**	708 West Lincoln, Maryville, MO 64468; 816/582-8906	**751-9465**	**116A1**
Bartelsmeyer, Linda	**132**	1606 S. Adams Ave., Aurora, MO 65605; 417/678-5822	**751-9806**	**1051**
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Bland, Mary	**43**	6135 Indiana, Kansas City, MO 64130; 816/483-8683	**751-2770**	**314**
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Broach, David W.	**102**	2007 Ronnies Dr., Arnold, MO 63010; 314/282-9986	**751-3264**	**105G**
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Canuteson, Greg	**34**	623 West Kansas, Liberty, MO 64068; 816/781-8560	**751-4069**	**410B**
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Champion, Norma	**134**	3609 S. Broadway, Springfield, MO 65807; 417/865-2815	**751-2583**	**105F**
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Crump, Wayne F.	**152**	606 Pine St., Potosi, MO 63664; 314/438-3418	**751-2101**	**310**
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Daniels, Fletcher	**41**	3537 Askew, Kansas City, MO 64128; 816/924-1513	**751-3158**	**303B**
Davis, Dorathea	**63**	2017 Menard, St. Louis, MO 63104; 314/773-4770	**751-2606**	**305B**
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Donovan, Laurie B.	**74**	7 Ipswich Ct., Florissant, MO 63033; 314/741-1443	**751-2135**	**200B**
Dougherty, Patrick	**67**	4031 Parker Ave., MO 63116; 314/772-1948	**751-3599**	**313C**
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Elliott, T. Mark	**127**	2 South Main, Webb City, MO 64870; 417/673-8464	**751-5458**	**135AA**
Enz, Catherine S.	**99**	10018 St. Simon Ct., St. Louis, MO 63123; 314/435-0220	**751-9768**	**109I**
Evans, Brent	**92**	4 Westbrooke Terr Ct., Manchester, MO 63021; 314/878-7887	**751-9765**	**105J**
Farmer, Nancy	**64**	5843 Waterman, St. Louis, MO 63112; 314/721-3083	**751-1400**	**407A**
Farnen, Theodore W.	**21**	1626 University Ave., Apt A, Columbia, MO 65201; 314/443-5501	**751-9681**	**236B**
Fiebelman, Ken	**150**	1202 Gertrude St., Salem, MO 65560; 314/729-5707	**751-2108**	**304A**
Fitzwater, Rodger	**36**	RR 2, Box 206, Norborne, MO 64668; 816/484-3501	**751-9757**	**400CA**
Foley, James Michael	**81**	3274 Adie Rd., St. Ann, MO 63074; 314/426-7675	**751-0855**	**405A**
Ford, Louis H.	**58**	3229 North 20th St., St. Louis, MO 63107; 314/241-1626	**751-2383**	**402B**
Foster, Bill I.	**156**	Rt. 9, Box 252-1, Poplar Bluff,, MO 63901; 314/785-1484	**751-3859**	**116-1**
Franklin, Richard	**53**	18005 Cheyenne, Independence, MO 64056 816/796-3088	**751-6535**	**404A**
Froelker, James V.	**111**	7437 Highway H., Gerald, MO 63037; 314/925-4587	**751-6668**	**135BA**
Garnett, Jess	**151**	P.O. Box 801, West Plains, MO 65775; 417/867-5651	**751-7017**	**114B**
Gaskill, Sam	**131**	HCR 79, Box 345, Washburn, MO 65772; 417/435-2304	**751-9801**	**101G**
Gaw, Steve	**22**	P.O. Box 314, Moberly, MO 65270; 816/263-9000	**751-2749**	**110A**
Gibbons, Michael R.	**94**	651 Pearl Ave., Kirkwood, MO 63122; 314/821-4616	**751-2853**	**106B**

Goward, Russell	**60**	5000 Tyus Ct., St. Louis, MO 63115; 314/381-6808	**751-2704**	**205**
Graham, Jim	**106**	Rt. 1, Box 145, Fredericktown, MO 63645; 314/783-7707	**751-3455**	**105B**
Gratz, William (Bill)	**113**	2315 Rt. M., Jefferson City, MO 65101; 314/635-4168	**751-0665**	**206C**
Green, Timothy P.	**73**	617 Science Hill, St. Louis, MO 63137; 314/869-9376	**751-6845**	**408A**
Griesheimer, John E.	**109**	33 Oxford Dr., Washington, MO 63090; 314/239-2523	**751-3678**	**106A**
Griffin, Bob F.	**6**	204 Benjamin Dr., Cameron, MO 64429; 816/632-0011	**751-2700**	**308**
Gross, Charles	**18**	3018 Westborough Ct., St. Charles, MO 63301; 314/947-7893	**751-1141**	**201D**
Gunn, Russell	**70**	6723 Maryellen, Northwoods, MO 63121; 314/389-7349	**751-4726**	**135**
Hagan-Harrell, Mary	**75**	100 Florwood Ct., Ferguson, MO 63135; 314/521-5555	**751-5836**	**317D**
Hall, Glenn	**56**	10506 S. Perdue Rd., Grain Valley, MO 64029; 816/524-8111	**751-1464**	**203C**
Hand, Raymond W. (Bill)	**87**	545 Gascony Way, Warson Woods, MO 63122; 314/821-2040	**751-8510**	**109B**
Harlan, Tim	**23**	511 S. Glenwood Ave., Columbia, MO 65203; 314/874-2402	**751-9753**	**400CC**
Hartzler, Ed	**123**	303 Manor Ct., Belton, MO 64012; 816/331-0090	**751-2175**	**101F**
Hartzler, Vicky	**124**	22804 E. 299th St., Harrisonville, MO 64701; 816/884-5297	**751-9780**	**109F**
Heckemeyer, Joe	**160**	510 N. Main, Sikeston, MO 63801; 314/471-0550	**751-9829**	**415B**
Hegeman, Daniel J.	**5**	RR 1, Box 408, Cosby, MO 64436; 816/662-2645	**751-0246**	**103BC**
Hendrickson, Carl	**97**	4661 Markton Dr., St. Louis, MO 63128; 314/554-3183	**751-9766**	**101K**
Hickey, John	**80**	4458 Boswell, Woodson Terrace, MO 63134; 314/428-3683	**751-4670**	**317C**
Hohulin, Bubs	**126**	Rt. 4, Box 925, Lamar, MO 64759; 800/878-7126	**751-2165**	**135AB**
Hoppe, Thomas	**46**	12316 Charlotte, Kansas City, MO 64146; 816/561-2065	**751-9469**	**403A**
Hosmer, Craig	**138**	657 S. Weller, Springfield, MO 65802; 417/869-0581	**751-9474**	**207A**
Howerton, Jim	**120**	535 NW 1250, Chilhowee, MO 64733; 816/678-4501	**751-1484**	**105E**
Jacob, Kenneth B.	**25**	4810 St. Charles Rd., Columbia, MO 65201; 314/874-7777	**751-2419**	**112**
Kasten, Mary C.	**158**	1209 Sailor Circle, Cape Girardeau, MO 63701; 314/334-3111	**751-2459**	**101C**
Kauffman, Sandy	**45**	620 E. 90th Terr, Kansas City, MO 64131; 816/333-3826	**751-5543**	**115A**
Keeven, Ronald P.	**78**	1110 Scoville, Florrisant, MO 63031; 314/831-9596	**751-1410**	**116A2**
Kelley, Pat	**47**	627 SW Lemans, Lee's Summit, MO 64082; 816/254-5116	**751-1456**	**200BC**
Kelly, Glenda	**27**	3415 N. 3rd St., St. Joseph, MO 64505; 816/233-2614	**751-9755**	**130DC**
Kissell, Don	**17**	408 Sutters Mill, St. Peters, MO 63376; 314/997-7878	**751-9628**	**317B**
Klumb, Jason O.	**125**	P.O. Box 341, Butler, MO 64730; 816/679-5787	**751-2033**	**235BA**
Koller, Don	**153**	P.O. Box 135, Summersville, MO 65571; 417/932-4064	**751-2112**	**413A**
Kreider, Jim	**142**	P.O. Box 1980, Nixa, MO 65714; 417/581-8599	**751-2956**	**114A**
Lakin, Scott	**33**	3700 NE 49th Terr, Kansas City, MO 64119; 913/338-2525	**751-6600**	**406B**
Leake, Sam	**9**	RR 2, Box 61A, Laddonia, MO 63352; 314/373-5685	**751-7852**	**404B**
Legan, Kenneth	**145**	RR 2, Box 196, Halfway, MO 65663; 417/445-2241	**751-3819**	**200A**
Levin, David	**82**	11208 Sherwood Oak Ct., St. Louis, MO 63146; 314/432-6502	**751-9762**	**116-3**
Liese, Chris	**85**	1948A Marine Terr Dr., St. Louis, MO 63146; 314/878-4787	**751-1832**	**235BB**
Linton, William C.	**89**	17339 Cougar Trail, Grover, MO 63040; 314/458-0736	**751-1247**	**201B**
Lograsso, Don	**54**	404 Stonewall Drive, Blue Springs, MO 64014; 816/228-7551	**751-1487**	**101H**
Long, Elizabeth L.	**146**	Rt. 2, Box 39, Lebanon, MO 65536; 417/532-6946	**751-4451**	**101D**
Loudon, John	**88**	134 Burtonwood Dr., Ballwin, MO 63011; 314/623-6012	**751-9763**	**115G**
Luetkenhaus, Bill	**12**	742 Hancock Rd., Wentzville, MO 63385; 314/327-6539	**751-2176**	**233A**
Lumpe, Sheila	**72**	6908 Amherst, University City, MO 63130; 314/863-4918	**751-4265**	**311**
Marble, Gary	**130**	214 E. Main, Neosho, MO 64850; 417/451-1262	**751-9781**	**135AC**
Marshall, Thomas W.	**26**	310 E. Vest, Marshall, MO 65340; 816/886-3465	**751-2204**	**313A**
Marshall, William G.	**133**	RR 2, Box 72, Greenfield, MO 65661; 417/637-2516	**751-1347**	**109A**
May, Brian H.	**108**	One Metropolitan Square, 211 N. Broadway, Suite 2420, St. Louis, MO 63102; 314/436-9600	**751-0438**	**410A**
Mays, Carol Jean	**50**	3603 Hedges, Independence, MO 64052; 816/252-0900	**751-7639**	**206A**
McBride, Jerry E.	**149**	P.O. Box 292, Edgar Springs, MO 65462; 314/435-6639	**751-4950**	**411B**
McClelland, Emmy L.	**91**	455 Pasadena, Webster Groves, MO 63119; 314/962-1796	**751-1285**	**115C**
McLuckie, Steve	**44**	9738 Shepards Dr., Kansas City, MO 64131; 816/756-1818	**751-2437**	**412B**
Mitchell, James W.	**148**	P.O. Box 741, 201 Chestnut, Richland, MO 65556; 314/765-5150	**751-2143**	**107**
Montgomery, Jim	**147**	14031 Highway 60-63, Cabool, MO 65689; 417/962-3912	**751-7935**	**111**
Morgan, Annette N.	**39**	639 W. 57th Terr, Kansas City, MO 64113; 816/523-4041	**751-4485**	**312**
Murphy, Jim	**95**	9314 Cordoba Lane, Crestwood, MO 63126; 314/849-5914	**751-2150**	**109C**

Murray, Dana L.	**69**	2422 Mary, St. Louis, MO 63136; 314/388-0417	**751-5538**	**409B**
Naeger, Patrick A.	**155**	RR 2, Box 139, Perryville, MO 63775; 314/547-4526	**751-9812**	**103BB**
Nordwald, Charles	**19**	#20 Hawthorne, Warrenton, MO 63383; 314/338-4404	**751-2689**	**105D**
O'Connor, Patrick	**79**	4413 Claremont, Bridgeton, MO 63044; 314/298-7418	**751-2726**	**317A**
O'Neill, Matt	**66**	6414 Devonshire, St. Louis, MO 63109; 314/481-4267	**751-2126**	**403B**
O'Toole, James P.	**68**	5445 Finkman, St. Louis, MO 63109; 314/353-0864	**751-2251**	**405B**
Oetting, David A.	**122**	P.O. Box 734, Concordia, MO 64020; 816/463-7091	**751-9297**	**201C**
Ostmann, Cindy	**14**	445 Knaust Rd., St. Peters, MO 63376; 314/240-5376	**751-2250**	**115F**
Overschmidt, Francis S.	**110**	151 N. Outer Rd., Union, MO 63084; 314/583-5591	**751-2398**	**114C**
Pauley, Jim G.	**24**	P.O. Box 138, 500 Tandy, Ashland, MO 65010; 314/657-2294	**751-2162**	**401A**
Pouche, Fred	**30**	10015 NW Mirror Lake Dr., Kansas City, MO 64152; 816/741-6537	**751-9756**	**116-5**
Prost, Donald	**162**	1801 Marilyn Dr., Caruthersville, MO 63830; 314/333-2130	**751-2264**	**233B**
Pryor, Charles R.	**116**	410 W. Newton, Versailles, MO 65084; 314/378-4082	**751-4119**	**109H**
Reynolds, David L.	**77**	1325 Verlene Dr., Florissant, MO 63031; 314/839-1111	**751-9761**	**201BA**
Ribando, Anthony D.	**65**	5440 Daggett, St. Louis, MO 63110; 314/771-9911	**751-4220**	**315**
Richardson, Mark L.	**154**	P.O. Box 310, Poplar Bluff, MO 63901; 314/686-3342	**751-4039**	**204**
Ridgeway, Luann	**35**	19405 Platte Co. Line Rd, Smithville, MO 64089; 816/532-0032	**751-2238**	**101J**
Rizzo, Henry C.	**40**	575 Harrison, Kansas City, MO 64106; 816/833-4700	**751-3310**	**413B**
Robirds, Estel	**143**	Rt. 2, Box 2919, Theodosia, MO 65761; 417/273-4777	**751-2042**	**103BA**
Ross, Carson	**55**	3305 Park Ln, Blue Springs, MO 64015; 816/274-4435	**751-8636**	**105C**
Sallee, Mary Lou	**144**	914 NW 9th St., Ava, MO 65608; 417/683-4410	**751-2205**	**115J**
Scheve, May	**98**	6612 Gramond, St. Louis, MO 63123; 314/849-3704	**751-9472**	**206B**
Schilling, Mike	**136**	1027 S. New, Springfield, MO 65807; 417/862-2272	**751-2652**	**234**
Schwab, David	**157**	2835 County Road 435, Jackson, MO 63755; 314/243-5966	**751-6662**	**203A**
Scott, Delbert	**119**	P.O. Box 147, 700 E. 7th, Lowry City, MO 64763; 417/644-2244	**751-8793**	**201CA**
Sears, Jim	**1**	314 S. Adams St., Memphis, MO 63555; 816/465-7225	**751-7985**	**415A**
Secrest, Patricia K.	**93**	723 Country Heights Ct., Manchester, MO 63021; 314/843-6626	**751-4392**	**101A**
Shear, Sue	**83**	200 S. Brentwood, Clayton, MO 63105; 314/863-0975	**751-4163**	**302B**
Sheldon, Norman E.	**104**	5201 State Rd. H, De Soto, MO 63020; 314/586-2192	**751-7735**	**411A**
Shelton, O. L.	**57**	1803A Cora, St. Louis, MO 63113; 314/533-1322	**751-2198**	**407B**
Shields, Charles W.	**28**	Rt. 4, Box 59, St. Joseph, MO 64507; 816/233-8090	**751-9476**	**101E**
Skaggs, Bill	**31**	3613 North Park, Kansas City, MO 64116; 816/452-5328	**751-2199**	**414**
Smith, Philip	**11**	P.O. Box 486, Louisiana, MO 63353; 314/754-4577	**751-9459**	**207B**
Sombart, Paul	**117**	1102 Santa Fe Dr., Boonville, MO 65233; 816/882-5198	**751-2134**	**105A**
Steen, Don	**115**	Rt. 3, Eldon, MO 65026; 314/392-5992	**751-2077**	**109G**
Stokan, Lana	**76**	3555 Amblewood Dr., Florrissant, MO 63033; 314/838-6497	**751-9760**	**305A**
Stoll, Steve	**103**	716 Richard Ave., Festus, MO 63028; 314/937-0277	**751-1492**	**406A**
Summers, Don	**2**	Route 4, Box 209, Unionville, MO 63565; 816/947-2283	**751-0224**	**101B**
Surface, Chuck	**129**	2401 W. 29th, Joplin, MO 64804; 417/624-5695	**751-2173**	**201F**
Tate, Phil	**3**	901 West Grand, Gallatin, MO 64640; 816/663-3710	**751-1415**	**130DA**
Thomason, Larry	**163**	P.O. Box 523, Kennett, MO 63857; 314/888-4100	**751-8591**	**412C**
Thompson, Vernon	**37**	1330 Park, Kansas City, MO 64127; 816/474-8683	**751-1309**	**300B**
Treadway, Joseph L.	**96**	1456 Telegraph, Lemay, MO 63125; 314/878-4200	**751-2315**	**401B**
Troupe, Charles Quincy	**62**	5338 Claxton, St. Louis, MO 63120; 314/383-3814	**751-2851**	**113**
Van Zandt, Tim	**38**	3930 Campbell, Kansas City, MO 64110; 493/769-6980	**751-5282**	**400CB**
Vogel, Carl	**114**	311 Constitution, Jefferson City, MO 65109; 314/636-6165	**751-2076**	**116-2**
Wannenmacher, Philip P.	**139**	731 E. Smith, Springfield, MO 65803; 417/833-0854	**751-2948**	**201E**
Ward, Robert D.	**107**	1133 Adams Rd., Bonne Terre, MO 63628; 314/431-5225	**751-2317**	**309**
Whiteside, Dale	**7**	Rt. 2, Box 80, Chillicothe, MO 64601; 314/646-3182	**751-2917**	**102BA**
Wible, Connie	**135**	2138 E. Cambridge, Springfield, MO 65804; 417/869-0581	**751-2210**	**115B**
Wieland, Paul	**101**	1139 Ellen Dr., Imperial, MO 63052; 314/464-2610	**751-4749**	**115I**
Wiggins, Gary	**8**	Rt. 1, Box 12, New Cambria, MO 63558; 816/226-5619	**751-1042**	**110B**
Williams, Deleta	**121**	713 Tyler, Warrensburg, MO 64093; 816/429-6893	**751-2272**	**236A**
Williams, Marilyn A.	**159**	RR 1, Box 98, Dudley, MO 63936; 314/624-8333	**751-0728**	**400**
Witt, Gary	**29**	12 Southridge, Platte City, MO 64079; 816/431-2750	**751-9460**	**408B**
Wooten, Chuck	**137**	2146 N. Broadway, Springfield MO 65803; 417/864-4328	**751-6562**	**115D**

Legislative Issues

Here We Go Again

The 1996 Missouri General Assembly convened at high noon on January 4, and will be in session until 6:00 p.m. on May 17. As always, health care issues are high on the agendas of many legislators. Of the approximately 1,300 bills that will be introduced this year, some 300 of them would, if passed, have some impact on your practice. Some of the issues are new, and many we have been fighting for years. Of course, the Patient Fairness Act tops our list of priorities, and our insurance market reform bill is also an important initiative. Following, in no particular order, is a sampling of the many other issues we will grapple with in 1996.

Lay Midwifery

The legalization of the practice of lay midwifery is an issue that has been around for several years. Portrayed by its advocates as an "access" issue, the bill inches closer to passage every year. A prospective lay midwife could have very little training or education and still be licensed by the state to deliver babies. MSMA considers this a significant safety issue and will lobby against its passage.

Immunizations

MSMA is pursuing a change in the law to allow parents to delegate to another adult the authority to give consent for the immunization of a child. This bill also would require most health insurance policies covering children to cover, without deductibles, copayments, or coinsurance, all routine and necessary childhood immunizations.

Strengthen DWI Laws

Last session MSMA supported several bills that would have strengthened Missouri's DWI laws. Of particular note was an attempt to impose strict penalties on anyone under the age of 21 convicted of driving with .02% or more blood alcohol content (the so-called "zero-tolerance" concept). MSMA will be supporting these efforts again this year.

Generic Substitution

For several years the pharmacy lobby has introduced legislation to allow pharmacists to make a generic substitution unless you, the prescriber, in your own hand, write the words "Brand Medication Necessary" across the face of the prescription form. This bill will be reintroduced this year, and MSMA will oppose it again.

Definition of Emergency Services

MSMA will be supporting its emergency physicians in an attempt to define "emergency services" for insurance purposes. In the absence of a specific definition, insurers have been denying payment for emergency room care when the ultimate diagnosis determines that the case was not a true emergency. The emergency physicians also hope to prohibit preauthorization for emergency services, require payment for federally-mandated emergency room screening exams, and to make insurers liable in instances where the insurer and the attending physician disagree over proper treatment.

Direct Access to Specialists

MSMA also is supporting Missouri's dermatology and ophthalmology societies, both of which are seeking legislation to allow a managed care patient to bypass the primary care gatekeeper and consult directly with any panel dermatologist or ophthalmologist.

Maternity Coverage

MSMA has had introduced a bill to require health plans to provide coverage for a minimum period of time for a mother and her

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newborn child. Under our bill insurers must provide coverage for at least 48 hours of inpatient care following a vaginal delivery, and a minimum of 96 hours of inpatient care following a cesarean section. If the mother and the attending physician approve of an earlier release, coverage is mandated for several minimum post-delivery services provided in the home setting.

Informed Consent for Mental Health Treatments

Last year a bill was introduced to address the controversial issue of repressed memories and the so-called "false memory syndrome." The issue at hand is one that needs addressing, but this bill was significantly flawed. It would have imposed countless burdensome informed consent requirements on mental health providers, requirements which would have driven up the cost of providing care and impeded the delivery of needful services. At the request of the bill's sponsor, a special task force was formed to explore the issue and find appropriate remedy. Although that group has made progress, we suspect that the bill will be introduced again in 1996. Unless there are substantial changes, MSMA again will oppose this measure.

Universal Health Care

Although support for a Canadian-style single-payor health care system has declined in Jefferson City, this bill's proponents always fight the good fight. Under this plan all Missourians would be guaranteed free health care. There would be one payor - the state - and physicians would have to negotiate with the state on all fees for services. MSMA will oppose this measure.

Statute of Limitations

MSMA will work this year to secure passage of a bill to prohibit a disciplinary proceeding against any licensed professional unless formal charges are filed within five years of the alleged violation. Several safeguards are built into the package to ensure that the various licensing agencies will always be able to protect the public from dangerous practitioners.

Acupuncture

The acupuncturists will again push legislation to grant them licensure in Missouri. Last session their campaign included free acupuncture therapy for legislators and Capitol staffers. They have managed to generate interest and sympathy for their cause, and MSMA will have its hands full trying to stop them.

Workers' Compensation

The business community has made workers' comp reform one of its highest priorities for 1996. MSMA will be monitoring their efforts to ensure that any new proposals are acceptable. Possible reforms being mentioned include Medicare's fee schedule for physicians' services, and language that would allow the injured worker to choose a chiropractor for post-injury care.

Tobacco

Every year several tobacco-related measures are introduced. Some of these would strengthen anti-tobacco regulations, some would relax them. MSMA is very much supportive of all anti-tobacco bills and will continue to support that cause.

Marijuana

A proposal has been reintroduced to legalize the use of marijuana - the plant itself - for medicinal purposes. While MSMA does support carefully controlled scientific studies to evaluate its clinical efficacy, we do not support adding marijuana to the state's drug formulary.

Bicycle Helmets

MSMA will again support legislation to require all bicyclists to wear approved safety helmets. This proposal has gone down to defeat several times in the last few years.

Seatbelts in Pickups

Current law exempts pick-up trucks from the state's seatbelt law. MSMA again will support a measure that would mandate the use of seatbelts in all pick-ups except those used on farms.

Ban Fireworks Sales

MSMA again will support passage of legislation to ban the sale, use, storage, and possession of bottle rocket fireworks in Missouri. In recent years Missouri's ophthalmologists have sponsored this legislation.

Become a Key Contact

Now that you are aware of some of the issues pending in the 1996 General Assembly, you can appreciate how important it is that medicine's voice be heard. That is why we have developed the MSMA Key Contact Program.

The Key Contact Program is medicine's political strike force. It matches lawmakers with physicians from their district who will keep in touch on legislative issues. As a Key Contact, you will called upon to deliver medicine's message whenever important issues reach a critical point.

This direct approach has been very successful, and our Key Contacts enjoy it immensely! We want you to give it a try. It takes no special training - we'll guide you along the way. Just copy and fill out the form below and return it to MSMA, P.O. Box 1028, Jefferson City, MO 65102; or FAX: 573-636-8552.

Your involvement is Key to our success!

My state representative is:______________________________

My state senator is:______________________________

My name:______________________________

Address:______________________________

____

Phone:______________________________

Fax:______________________________

MMPAC **Missouri Medical Political Action Committee (MMPAC) is the Missouri State Medical Association's bipartisan political action committee. The committee works with state elected officials to make sure they understand every aspect of health care legislation.**

MMPAC contributions support candidates who support the legislative goals of physicians. Candidates are selected based on recommendations from MMPAC members and local districts.

Annual Membership Dues:
$250 - SuperPAC Member
$100 - Sustaining Member
$50 - Active Member

Send personal checks payable to MMPAC to: P.O. Box 1402, Jefferson City, MO 65102.

Legislation & MSMA Policies Start with You

The process of creating legislation or policy supported by the Missouri State Medical Association begins with the ideas and needs of our members.

The first step is stating those needs in the form of a resolution. Resolutions may be submitted by individuals, component medical societies, or groups of MSMA members.

To have a resolution be included in the delegates' handbooks for the MSMA Annual Meeting to be held April 11-14, 1996, at Tan-Tar-A Resort at the Lake of the Ozarks. Resolutions must be submitted by **February 26, 1996**.

Submit resolutions to: **MSMA**
113 Madison, P.O. Box 1028
Jefferson City, MO 65102
or fax to 573=636-8552

Legislative Affairs Committee

David O. Barbe, MD, *Mountain Grove*
A. J. Campbell, MD, *Sedalia*
Mrs. Nona Chapman, *Cape Girardeau*
Shavonne L. Danner, MD, *Leawood, KS*
Frederick W. Hahn, MD, *Independence*
Joan M. H'Doubler, *Springfield*
Deborah A. Jantsch, MD, *Kansas City*
Melvin C. Kasten, MD, *Cape Girardeau*
Jerry Kennett, MD, *Columbia*
Norman P. Knowlton, III, MD, *Springfield*
Robert N. Miller, MD, *St. Louis*
Becky Moore, *Joplin*
H. Jerry Murrell, MD,* *Columbia*
Charles Norland, MD, *St. Louis*
Daniel O'Sullivan, MD, *St. Louis*
Robert O. Schaaf, MD, *St. Joseph*
William C. Shell, MD, *Sikeston*
David Wilkinson, MD, *St. Louis*
Carol F. Williams, MD, *St. Louis*

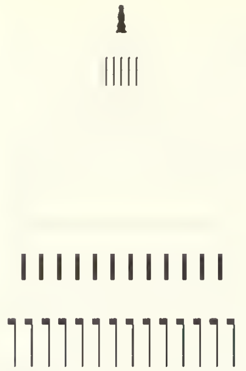
**chair*

Jan Meyer

The New Southern Medical Association Auxiliary President

Jan Meyer was installed as the President of the Southern Medical Association Auxiliary at their annual meeting in Kansas City in November. She is a past president of the Missouri State Medical Association Alliance and is currently the secretary-treasurer and acting president of the Lafayette-Ray County Medical Society Auxiliary.

Make Plans to Attend the 71st MSMAA Annual Meeting - April 12 - 15, at Tan-Tar-A Resort, Lake of the Ozarks. Our own Sandra Mitchell, AMA President-elect, will be our honored guest. The AMA-ERF Benefit Dinner will feature an art auction. The Dutch Treat Dinner will be at The Blue Heron. Bring the kids - activities are being planned for them.



Alliance Day at the Legislature

March 5 & 6, 1996

The Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend.

March 5

2:00 pm	**Deliver invitations to legislators.**
4:00 pm	**Alliance Board Meeting.**
6:30 pm	**Cocktails & Dinner, *Capitol Plaza Hotel.***
	MSMA lobbyist will discuss current legislative issues.

March 6

7:30 am	**Meet at the Capitol Building, *Rooms 3 & 4, lower level.***
8:00 am	**Legislators will begin to visit.**
	Coffee & rolls provided. You bring the conversation.
10:00 am	**Observe sessions in the House & Senate.**

Alliance Day at the Legislature event fee: $25.00

Name____

Address______________________________________

City____________________________ Zip________

County Society/Alliance__________________________

List names of legislators you will personally invite:

____

____

Please complete form and send with check for $25.00 payable to MSMAA, to Becky Moore, MSMAA Vice President - Legislation, 8367 Cedar Drive, Joplin, MO 64804, (417)623-1195.

Spouses are not only welcome to join us both days - they are encouraged.

A block of rooms has been reserved for MSMAA members. To reserve hotel accomodations at the Capitol Plaza Hotel, call (573)635-1231 by February 20, 1996.

Missouri Physicians' Health Program

Recognition of Key Supporters

(As of 12/26/95)

The Missouri State Medical Association and the Missouri Physicians' Health Program would like to thank the following institutions for their generous support to the MPH Program. It is because of these gifts that the MPH Program can continue to assist physicians who are having life problems that prevent them from functioning at their best.

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A Reminiscence

Wilfred E. Wooldridge, MD
Springfield, Missouri

The year, 1943. December, I believe it was. A cattleman from Texas was returning home by railroad after visiting his son, a student in the Harvard School of Medicine.

Just before boarding the train, or shortly after, he developed a fulminating staphylococcic infection on the upper lip. By the time he reached St. Louis he was sick. By the time he changed trains and reached Poplar Bluff he was really sick. Someone returned him to St. Louis and he was placed in a room on the west side of Barnes Hospital, adjacent to Kingshighway, in what we then referred to as the Private Pavilion. By that time he was moribund. He became the patient of Dr. Louie Aitken, a popular and very competent internist.

It was almost at the same time the first supplies of penicillin became available. Most of it was reserved for the military, but a very small amount was allotted for civilians, and Barnes Hospital received some of that. I don't recall the name of the doctor who was placed in charge of the closely monitored supply. Dr. Aitken requested some of that precious penicillin for the treatment of the cattleman, who otherwise was certainly going to die.

I can still remember those vials of penicillin. Each contained 10,000 units. The material in the vial was brown and had a musty smell when it was prepared for injection. His dosage was 10,000 units every three hours, given in one gluteus, then the other. Those injections must have been quite painful because as he became more alert, every shot was almost a wrestling match, accompanied by outcries of his numerous and vociferous relatives.

This went on for about five days. Dr. Aitken dropped by at proper intervals. He was better within 24 hours of beginning his treatment. The catch was that Dr. Frank Wissmuth, now retired and living near Hermann, Missouri, and I alternated twelve hour shifts giving his injections, and putting up with abuse from all the family.

Anyway, he recovered splendidly. Before a week was out he returned home on his train and nobody was happier than Frank Wissmuth and me.

The bottom line? I presume Dr. Louie Aitken's bill was paid and I did hear he was given a bonus of a fine saddle horse.

Where did that leave we poor interns? We were the bad guys and nobody even told us good-bye.

The real interesting fact of all this is that he was the first patient treated with penicillin in Barnes Hospital. MoMed

Featured Speaker for the 138th MSMA Annual Meeting

April 11-14, 1996 Tan-Tar-A Resort
Lake of the Ozarks

Pitfalls to avoid when negotiating managed care contracts

Essential preparation for capitation

Packaging physician services for managed care

How to become more effective and efficient in a managed care practice

Stanley Pappelbaum, MD

Stanley J. Pappelbaum, MD, MBA, is one of a small but growing number of Physician Executives in the United States - MDs who have received an advanced business degree. He is co-founder and managing partner of Professional Health Consulting Group (PHCG) in Del Mar, California, a national company of physician executives who are devoted to analyzing and managing change for complex health care clients. PHCG has gained unique competence in physician-driven integrated systems - both community and academic, in partnership with hospitals and/or employers and/or payors. His primary objective is to provide a strategic framework for successful change, especially involving physicians, in complex health systems.

Dr. Pappelbaum is a Senior Strategist (Physician Relations) for the SunHealth Alliance of Charlotte, NC (an alliance of 300 not-for-profit hospitals in the Southeastern United States). He is the immediate past chair of the Medical Quality Subcommittee of the California Public Employees Retirement System (CALPERS), and the National Council on Pediatric Practice of the American Academy of Pediatrics. He is also a member of the Technical Advisory Panel for the National Leadership Commission on Health Care in Washington, D.C.

Dr. Papplebaum is a professor of pediatrics and has taught in the University of California, School of Medicine, system since 1967. He is Certified by the American Board of Pediatrics, the American Board of Pediatric Cardiology, and the American Board of Medical Management.

He completed his undergraduate work at McGill University, Montreal and received his medical degree from the University of British Columbia Faculty of Medicine, in Vancouver. He completed his residency in pediatric medicine at Montreal Children's Hospital of McGill University and did graduate studies in cardiovascular physiology and a fellowship in pediatric cardiology at the University of California, Los Angeles. He also received a master of science degree in management (health option) from the Massachusetts Institute of Technology.

Resolutions for the 1996 Annual Meeting of the House of Delegates must be submitted by February 26 to be included in the Delegate's Handbook. Resolutions may be submitted by individuals, component medical societies or groups of MSMA members.

CME Calendar

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for free listing in *Missouri Medicine*. Please remember to include the name of the individual who can be contacted at you institution for additional information about your CME events. Organizers of out-of-state CME opportunities may contact the Managing Editor for advertising information.

JANUARY

22 - *St. Louis*: Neurosurgical Approaches to the Carotid Artery. 9 credit hours. Call 314/535-4000.
22 thru 26 - *St. Louis*: The Medicolegal Death Investigator Training Course. 33 credit hrs. Call Mary Fran Ernst 314/522-6410, ext. 6509.
24 - *St. Louis*: The Eighth Annual Joseph E. Flynn Lecture Series. 4.5 credit hours. Call Judith O'Buin Brandes 314/569-6290.
26 - *St. Louis*: Advanced Trauma Life Support. Call 314/577-8167.
26 & 27 - *Kansas*: Adolescent Suicide: Assessment, Treatment & Prevention. 12 credit hours. Call Menninger Continuing Education 1-800-288-7377.
26 & 27 - *St. Louis*: Techniques of Lumbosacral Fixation and Decompression. 20 credit hours. Call 314/535-4000.
26 & 27 - *St. Louis*: Techniques of Lumbar Decompression and Fixation. 17 credit hours. Call Salomao Segal, MD 314/535-4000.
27 - *St. Louis*: ATLS Refresher Course. Call 314/577-8167.
27 - *St. Louis*: Dental Care Delivery and Managed Care. Call Judith O'Guin Brandes 314/569-6290.
28 - *St. Louis*: ATLS Instructor Course. Call 314/577-8167.

FEBRUARY

12 - *St. Louis*: Controversial Aspects of the Regulation of Mammography. Call 314/362-7130.
13 thru 15 - *St. Louis*: Endoscopic Plastic Surgery. 25 credit hours. Call 314/535-4000.
16 thru 18 - *St. Louis*: Advanced Human Neuroanatomy for Physicians and OR Personnel. 20 credit hours. Call 314/535-4000.

MARCH

11 - *St. Louis*: Technology Assessment, Outcomes Research, and Decision Making in Diagnostic Radiology. Call 314/362-7130.
13 thru 15 - *St. Louis*: 4th Annual Refresher Course and Update in General Surgery. Call 314/362-6893.
15 thru 17 - *St. Louis*: State of the Art Temporomandibular Joint Microsurgery. Part 1, 15 credit hours; Part 2, 8.5 credit hours. Call 314/535-4000.
21 & 22 - *St. Louis*: Clinical Pulmonary Update. Call 314/362-6893.
22 & 23 - *St. Louis*: Neurosurgical Endoscopy. 14 credit hours. Call 314/535-4000.
25 thru 29 - *St. Louis*: Spinal Fracture Fixation. Call Salomao Segal, MD 314/535-4000.
30 - *St. Louis*: Cardio-Pulmonary Bypass and Coagulation Deficiencies for Surgeons. Call 314/362-6893.
30 - *St. Louis*: Advances in Hemostasis Management with Cardiac Surgery. 6.5 credit hours. Call 314/362-6893.

APRIL

8 - *St. Louis*: Radiology's Future: Orwellian? Elysian? or What? Call 314/362-7130.
12 - *Kansas City*: Symposium For and About Women Physicians. 6 credit hours. Call 816/932-5140.
16 - *St. Louis*: Fractures of the Upper Extremity. Call Salomao Segal, MD 314/535-4000.
19 & 20 - *St. Louis*: Advanced Trauma Life Support. Call 314/577-8167.
19 thru 21 - *Osage Beach*: Mental Health and Aging Conference. Call 573/577-8167.
20 - *St. Louis*: ATLA Refresher Course Call 314/577-8167.
22 thru 26 - *St. Louis*: The Medicolegal Death Investigator Training Course. 33 credit hrs. Call Mary Beth Ernst 314/522-6410, ext. 6509.
23 thru 25 - *St. Louis*: Microsurgical Approaches to the Cavernous Sinus Call Salomao Segal, MD 314/535-4000
25 & 26 - *St. Louis*: Intracranial Aneurysms. 17 credit hours. Call 314/535-4000.
25 & 26 - *Overland Park, KS*: Current Management In Critical Care. 17 credit hours. Call Linda F. Smutz, Kansas City Southwest Clinical Society, 816/523-3383.
26 thru 28 - *St. Louis*: 2nd Annual Primary Care Update. Call St. Louis University 1-800-553-2712.

MAY

2 & 3 - *St. Louis*: Driving and the Aging Population. Call 314/362-6893.
13 - *St. Louis*: Functional Brain Imaging. Call 314/362-7130.

JUNE

21 & 22 - *St. Louis*: 10th Annual Frontiers in Endourology. Call 314/362-6893.
25 thru 28 - *St. Louis*: Surgical Management of the Skull Base. Call Salomao Segal, MD 314/535-4000.

JULY

25 thru 27 - *St. Louis*: Clinical Allergy for the Practicing Physician. Call 314/362-6893.

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Missouri Medicine

Journal of the Missouri State Medical Association

February 1996

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- NEW! Radiology Quiz #1
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On the Cover: "Mountain Farm" a watercolor by John W. Fries, MD. Dr. Fries is a retired radiologist, a clinical professor at St. Louis University School of Medicine and a volunteer physician at the St. Louis Regional Hospital.

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, [ISSN 0026-6620] is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. **Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept., P.O. Box 1028, Jefferson City, MO 65102.** The subscription price per year for non-members is $60.00. Annual subscription for members is included in the annual membership dues. Single copies are $8.00 and the per copy cost of the annual August Directory is $40.00. Copyright 1996 by the Missouri State Medical Association. The opinions expressed by the authors are not necessarily those of the Missouri State Medical Association nor should publication be considered an endorsement by the MSMA. Printed by the Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

Teaching by Example

J. Regan Thomas, MD, Editor

Much has been made in recent years about the role and value of preventative health. In particular, healthy life-styles have been pointed out as one of the answers to an increasingly difficult health care problem in this country. Wellness therapy and life-style health enhancement activities are mentioned frequently, but one wonders how often an active process is involved with passing this data on to our patients and to the American population. It seems that each week new epidemiological studies come forward that indicate certain life-style activities and habits including diet, exercise and sleep patterns may significantly affect our longevity as well as quality of life. As physicians, and hopefully the primary directors for a healthy life-style, I wonder how good are we as examples, or as the cliché goes, "do we practice what we preach?"

For example, the medical profession in my view has done an excellent job of leading the way in terms of informing the public on the dangers of smoking and tobacco use. The numbers of physicians who smoked in the past and quit, as well as the overall numbers of nonsmokers, make physicians a very admirable group in terms of tobacco usage. That has not always been the case. In fact, I remember seeing ads as a child where physicians were used in advertising for cigarettes. That era is certainly gone, but I do still have a few physician friends who smoke in spite of the undeniable risk to their health. I would suggest that this is a particularly unfortunate example which they pass on to their patients and community. I can think of one friend in particular who has extensive training in head and neck cancer, a disease process that has very close and direct links with smoking as an etiologic agent. I can remember seeing him routinely between cases smoking a cigarette before he went on to start the next smoking-related cancer operation. It's tough to stop smoking, nobody denies that, and I suspect much more difficult for some individuals than others. Nonetheless, one of the prevailing factors, at least for physicians, should be that we need to be setting a good example for our patients.

A lot has been made about the importance of proper sleep habits and the health difficulties related to sleep deprivation. I wrote an editorial in the past year about studies that relate that adolescents in particular are having difficulty with sleep deprivation. Studies have pointed out that this age group probably needs at least 9 ½ hours sleep. Most teenagers do not get that and some of their performance in terms of school reflect that societal difficulty. In fact, if you remember from that editorial I pointed out that the Minnesota Medical Association had contacted their state school districts to suggest the schools start later in the morning to better reflect typical sleep patterns for school age kids.

Those kinds of health-oriented factors are related to other seemingly unrelated findings. For example, a North Carolina study showed that 16-25 year olds accounted for 55% of accidents from automobile drivers falling asleep, and in fact, motor vehicle accidents were the second highest cause of death in that same age group. It followed that many of those deaths may have been related to poor recognition of sleep patterns.

Similar sleep problems have recently been recognized in the sleep cycles of adults and difficulties related to cardiac disease as our natural circadian rhythms are altered. A recent Harvard study that has been reported in the popular press followed 121,000 female nurses. After adjusting their data for other cardiac risk factors including cigarette smoking, they noted that the women who had been working "rotating shifts" for more than six years were 50-70% more likely to have heart attacks than those who did not work rotating shifts. This appears to be a previously unrecognized important risk factor, at least in women, and the changes in sleep patterns and habits should be included in one's health status evaluation. Although the risk of shift work is probably moderate compared to other factors like smoking or lack of exercise, it certainly is a factor that is part of our life-style that should not be overlooked.

Probably few other groups have as irregular and erratic sleep patterns as physicians. Particularly those groups like the nursing professionals in the study, who work varying shifts and certainly those groups that traditionally have middle-of-the-night calls, such as obstetricians, should be aware of these risks. Recent years have seen significant scrutiny of physicians in training and house officer sleep schedules. Most of this attention was brought on by litigation such as that recently in New York which suggested some blame for alleged poor patient care on sleep deprivation on the part of house staff members. Since that time, and in recent years, significant changes and additional scrutiny over call schedules and time away from the hospital have been increasingly mandated by the residency review committees and in some states' legislative bodies.

All of that brings to mind some self-evaluation as practicing physicians. Are we really getting adequate amounts of sleep and arranging our work situations so that our sleep patterns and habits are minimally affected? The answer for most of us, I think, is "no."

How many of us are getting proper amounts of exercise and avoiding sedentary life-styles? Even more difficult perhaps, how many of us are at our optimum weight and controlling our dietary habits appropriately? All of us could answer the question, "What's the optimum amount of exercise for a healthy life-style?" Although those directives change slightly from time to time, all of us realize that we should be getting at least 30-40 minutes of active exercise three or four times a week, even more if possible. Unfortunately, I would guess that the majority of practicing physicians do not approach that and are more likely to have their activity levels well within the bell-shaped curve of the average American citizen.

Most of us are in hectic life-styles with demanding schedules that allow for grabbing quick bites of probably unhealthy food between cases and meetings. Like most Americans, most of us could stand to shed a few pounds and some of us are significantly overweight.

All of these areas are, of course, easily rationalized, and we find multiple examples as we defend our situations. We have busy, hectic life-styles with tremendous demands on our time. We are only human and that may be the biggest problem for most of us. Nonetheless, if anyone is to be the leader of directing our patients, families and loved ones to a healthier life-style, shouldn't it be the physicians as a group?

We often have ourselves in an ironic frame of mind where we pride ourselves on the number of hours that we put in or the large numbers of patients that we have served. But, from to time, self-evaluation perhaps begs the question, "Are we really serving our patients as well if we are not good examples?" Are we really performing at our best if we are being negligent in our own health and allowing our life-styles to negatively impact our well being?

These are all tough questions and tough decisions. The empirical answers are certainly easier to come by than real life solutions. As a group we have a tradition of hard work and long hours, but would we be serving our patients as well as ourselves and families if we were more conscientious about following our own advice towards a healthier life-style?

With so many people watching us as a profession so closely these days, perhaps it is time that we also begin to include a greater degree of constructive introspection. It is time for us to follow some of our own good advice in terms of day to day health and life-style choices to demonstrate the benefits for our patients through example. MoMed

Middle Ground

Frederick Hahn, MD, MSMA President

As I reflect and write this article, individual physicians and varying-sized physician groups all over the state of Missouri have, or are considering, new associations and alignments. These associations would never have been considered before the advent of managed care.

It is my observation that most of the arrangements are pure and simple efforts of self preservation. At one extreme, we have high profile specialists who at this point in history find themselves with very lucrative practices that they hope to maintain.

At the other end of the spectrum are those who have had their practices piecemealed away by managed care to the point that they fear they will have no practice at all if they don't succumb to one of these organizations.

As has been expressed so many times, the driving force behind this entire disarray continues to be the bottom line of managed care. We as physicians find ourselves sucked further into this trap which replaces practice autonomy with adversarial controlling interests.

This all seems so foreign to the tenant with which we entered into the medical profession. What were the driving forces which allowed us as physicians to so gladly accept and endorse the Oath of Hippocrates?

The American Way

When I was a boy, I loved to read about Abraham Lincoln and the extremely humble background from which he ascended to the presidency of the United States. I loved the stories about the miles he walked and the hardships he suffered in order to acquire just one more book or treatise to read. The concept of log splitter to President or "rags to riches" has become the "American Way."

A current example would be Bill Gates who has achieved great success. Mr. Gates worked while in college. After his first year, he took a leave of absence from college in order to tirelessly pursue his passion and belief in the future of computer software. He never returned. Today at just over 40 years of age, he is the wealthiest man in the world. He represents a glorious example of how the belief in a concept, the will to work tirelessly, and the tenacity of pursuit can lead young persons not only to chase windmills but also to find and seize them.

Judeo-Christian Ethic

The majority of Missouri physicians grew up believing that we should love our God with all of our heart, mind and soul and that we should love our brothers as ourselves.

If this ethic has not blatantly affected our practice modality, it has at least subconsciously guided our interpersonal relationships and more specifically our doctor-patient relationships.

From childhood on, we have enjoyed the fairy tale versions of goodness. The story of Robin Hood has been a perennial favorite. The act of taking from the rich and giving to the poor rests in the hands of the voters. During and following World War II, the electorate of the U.S. was sympathetic with congressional candidates favoring subsidies and give-way programs. Concerning health care, the great "foot in the door" came when Congress instituted Medicare in 1965. Unfortunately, the ethical intent then and since has been overshadowed by an explosion in the size of the associated bureaucracy.

A chicken in every pot; a car in every garage; guaranteed basic education; basic health care; food and housing for those who cannot afford them; and even representation in our legal system, all reflected the voting conscience of we people. Not until the last congressional election did the people of the U.S. mandate the need to re-evaluate the whole system.

Middle Ground

As Dr. Howard Braby, our MSMA first vice president, and I talked through this lengthy dilemma on the way to our last MSMA Council meeting in Jefferson City, we agreed that the concept of incentive as found in the "American Way" is vital to progress, production, and the creation of new ideas.

At the same time it seems and feels appropriate to be guided by those general ethical principles which are the vital threads in every major religious movement. As best put by Winston Churchill, "The flame of (religious) ethics is still our best guide...only on this basis can we reconcile the rights of the individual with the demands of society."

Howard said, "We have to find some way to reach middle ground." By middle ground, he meant retain incentive while still being fair, just, and equitable.

The only answer we could agree on is not a new one. The answer is to collectively focus on the health care needs of our patients.

As physicians, we **must** concentrate on how we can collectively provide the **best** possible health care for all the patients we attend.

Isolated and selfish bottom line turf battles, whether between high profile specialty groups, massive managed care organizations or major insurance companies, have no place in a rational formula.

As the family of medicine, **our bottom line** must be to provide caring health care to the citizens of our state. MoMed

The 138th Annual Convention of the Missouri State Medical Association

Marriott's Tan-Tar-A Resort
Lake of the Ozarks
April 11-14, 1996

***Guest Speaker*: Nancy W. Dickey, MD**

Dr. Dickey is Vice-Chair of the AMA Board of Trustees and Executive Committee.

***Featured Speaker*: Stanley Pappelbaum, MD**

Dr. Pappelbaum is co-founder and managing partner of Professional Health Consulting Group of Del Mar, California, a national company of physician executives.

Special Events: **House of Delegates** general sessions convene Saturday, April 13; first session at 9 a.m. and second session from 2-4 p.m. The second general session will include a panel discussion of physician organizations by representatives of Renaissance Healthcare Partners, Inc. of Kansas City, Mid-Missouri Medical Care, and Jefferson City Medical Group, and Missouri State Medical Services, Inc. ▪ Physicians will be recognized and honored for their leadership, community service and dedication to medicine. ▪ Events are set for component societies, medical schools and medical specialty groups. ▪ The MSMA Alliance is having an art auction, with professional auctioneer Oralee Puckett, to benefit AMA-ERF. ▪ Child care services are being organized in conjunction with the resort's activities desk - so bring the family.

Speed-up your convention registration by preregistering. A preregistration form is located on page 10 of the Preliminary Program in the December issue of *Missouri Medicine.* If you need a registration form, call MSMA, (573)636-5151. Hotel reservations must be made before March 8 to guarantee accomodations. For room reservations call 1-800-TAN-TARA. Be sure to ask for the MSMA group rate.

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Radiology Quiz #1

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

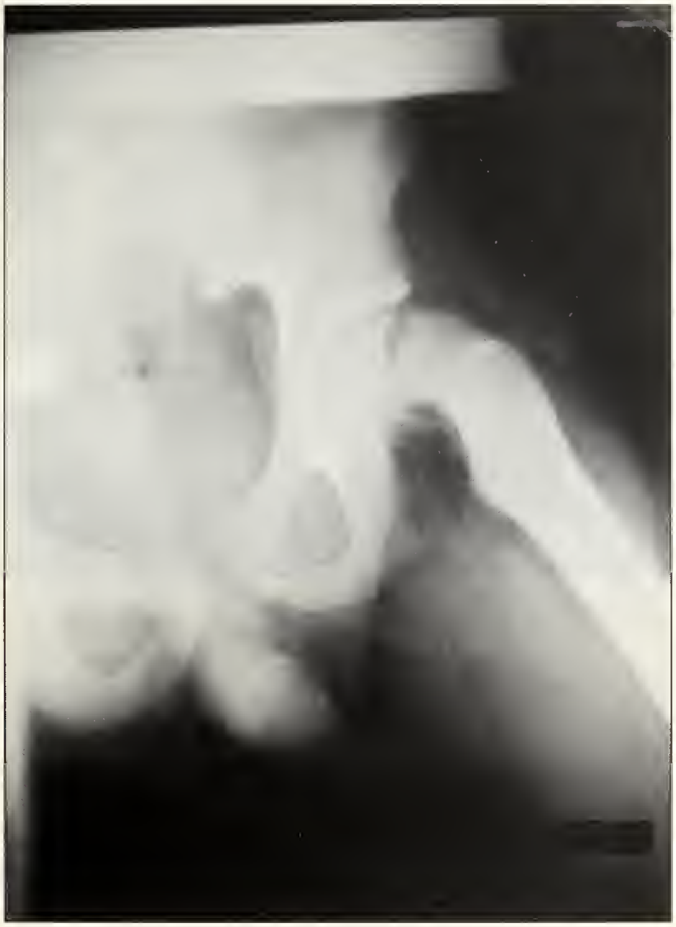


Figure 1

A 14-year-old boy presented to the clinic with left hip pain and a limp without known trauma. An A.P. radiograph of the left hip was performed (Fig 1).

What is the diagnosis?

a. Slipped femoral capital epiphysis
b. Legg-Calve-Perthes Disease
c. Fractured femoral neck
d. Hip dislocation

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

ANSWER: a. Slipped femoral capital epiphysis

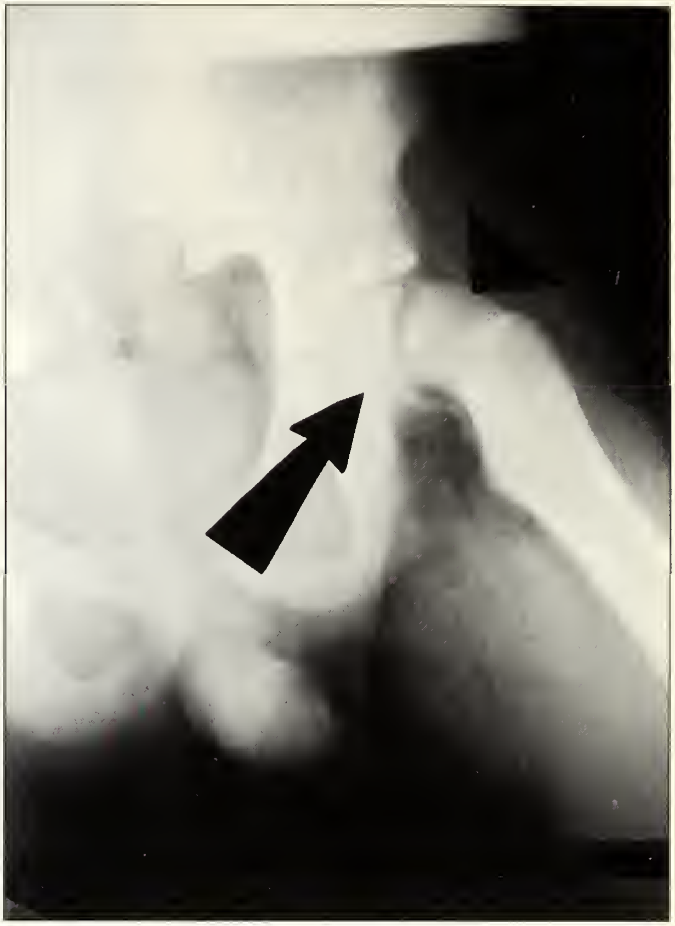
The A.P. radiograph of the left hip with slight obliquity (repeat Fig 1) shows the femoral head epiphysis (arrow) to be displaced posteriorly and medially in relation to the metaphysis (arrowhead). The indicates a slipped femoral head epiphysis, and option (A) is the correct response. This was confirmed at surgery, and metallic pin fixation was performed.

Slipped femoral capital epiphysis occurs usually in male patients, ages 11 to 15. Etiology is unknown, but most patients are obese. It is theorized that rapid growth at the growth plate around puberty with the added stress of obesity causes a fracture through the growth plate and subsequent slippage. Less common etiologic factors include hypothyroidism, hypopituitarism and previous radiation. Patients present with limp and pain which may be at the hip or knee. A lateral or oblique radiograph of the hip is very helpful, since the slippage is usually posterior, and may not be visible on the A.P. radiograph.

Option (B), Legg-Calve-Perthes Disease, represents idiopathic avascular necrosis of the femoral head in children. Radiographically, the femoral head epiphysis is flattened and irregular, unlike the smooth appearance of the test case. Option (B) is therefore incorrect.

Option (C), femoral neck fracture is incorrect since the discontinuity is at the femoral head growth plate, not the femoral neck. Also, femoral neck fractures are extremely uncommon in children.

Option (D) hip dislocation is incorrect since the femoral head remains normally articulated with the acetabulum.



Repeat Figure 1

Reference

1. Azouz EM, Karamitsos C, Reed MH, et al. Types and complications of femoral neck fractures in children. *Pediatric Radiology* 1993;23:415.
2. Kirks DR. *Practical Pediatric Imaging*, 2nd Edition, Little Brown & Co., 1991, p371-75.

Guidelines for Physician Responsibilities in Subacute Care

1. Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week.

2. Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.

3. Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.

4. Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.

5. Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.

6. Physicians are responsible for:
    - Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care.
    - Identifying and appropriately utilizing subacute care facilities in their communities.
    - Oversight of physician credentialing in subacute settings.
    - Promoting medical staff organization and by-laws that may be needed to support peer evaluations.
    - Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.

7. Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.

8. Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.

9. Attending physicians should:
    - Make an on-site visit to review the interdisciplinary care plan within 72 hours of admission.
    - Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly.
    - Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit.

10. Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.

Reference:
AMA Board of Trustees Report 21-I-95

American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American Geriatric Society
American Medical Directors Association
American Thoracic Surgery
American Society of Clinical Oncology
American Society of Internal Medicine
American Medical Association

A Health Care Professional's Duty to Warn: *Tarasoff* Now Applies in Misouri

Crystal S. Seifert

The Missouri Court of Appeals, Western District, recently decided a case which established a duty to warn for health care professionals. In *Bradley v. Ray and Strnad*,[1] the court held that a victim can bring a suit for money damages against health care professionals based upon breach of a duty to warn an intended victim.

In 1976, the California Supreme Court decided the landmark case *Tarasoff v. Regents of the University of California*.[2] This was the first case to impose a duty upon any health care provider to warn potential victims of a patient's dangerous propensity toward a victim. *Tarasoff* held a psychotherapist liable for the violent acts of his patient where the therapist failed to act with reasonable care when he knew, or should have known, of the patient's dangerous propensity.

The *Bradley* Case

K.P., a minor female was allegedly sexually abused by her stepfather, Mr. Pope.[3] The alleged abuse began in 1980 when K.P. was four years old, and continued until she was 13 years old, in 1989. K.P.'s mother became aware of the abuse and arranged for two licensed psychologists to provide psychological services to the stepfather. (Throughout this article, the psychologists involved will be referred to as Dr. A and Dr. B.) The psychologists provided treatment in 1988 to Mr. Pope who continued to live in the home with K.P. The petition filed by K.P.'s next friend alleges that both Dr. A and Dr. B knew the sexual abuse continued during the treatment and after the treatment was terminated. Allegedly, neither Dr. A nor Dr. B reported the abuse to the Division of Family Services or to any law enforcement agencies, or warned the victim or her family. Under Missouri law, all health care providers are mandatory reporters of suspected child abuse, including sexual abuse.[4] The alleged abuse of K.P. by Mr. Pope continued after termination of his treatment.

On December 30, 1993, Norma Bradley,[5] acting as next friend of K.P., filed a civil suit seeking monetary damages for injuries to K.P. due to the prolonged abuse by her stepfather. The law suit against the two psychologists alleged four counts: (1) aiding and abetting child abuse, (2) common law negligence for failing to warn officials or the victim of the suspected child abuse, (3) negligence per se for violating the Missouri statute requiring health care providers to report suspected child abuse to the Division of Family Services,[6] and (4) a prima facie tort. The trial court dismissed the case for failure to assert a claim for which the court could grant relief. The Western District Court of Appeals overturned the trial court and held that an action could be brought against the psychologists for breaching a duty to warn. It dismissed the other counts. In its decision, the court imposed upon all health care professionals a duty "to warn the intended victim or communicate the existence of such danger to those likely to warn the victim including notifying appropriate enforcement authorities.[7]

Development of Duty to Warn

Traditionally, the common law provided a cause of action for negligence if the facts of a lawsuit showed: (1) an existence of a duty on the part of the defendant to protect the complainant from injury; (2) failure of the defendant to perform that duty; and (3) an injury to the complainant caused by the defendant's failure to perform the duty. A health care professional did not have a duty to control the conduct of another person nor to warn an intended victim. Now however, where the defendant professional is in a special relationship with a third person, a duty arises. A therapist's relationship with a patient is sufficient to create a special relationship with a third party (the potential victim) under the California Supreme Court holding in *Tarasoff.*

Tarasoff involved a patient who communicated to the therapist his intention to kill his ex-girlfriend. Although the patient did not identify the victim by name, he provided enough information to identify his ex-girlfriend as the intended victim. The therapist reported his client's dangerousness to campus police but did not warn the woman. Two months later, the patient killed the victim. The California Supreme Court held that the therapist had a duty to warn the foreseeable victim of the danger when the therapist knew, or should have known, the patient posed a serious threat of violence.[8] The court recognized the old common law general rule that there is no duty to control the conduct of a third person, but it established a "special relationship" exception to that rule.

Similarly, Missouri's common law provided that a private person did not have a duty to protect third persons from deliberate criminal acts by another. But with *Bradley*, Missouri has followed *Tarasoff* to create an exception for circumstances involving a "special relationship." When such a relationship exists between the health care professional and patient, the relationship creates an obligation for the health care professional to act for the benefit of the third person.

Missouri courts will analyze the factors enumerated in Table 1 to determine the existence of a health care provider's duty to warn. The *Bradley* court's imposition of this duty upon health care providers was not surprising, particularly in light of the policy considerations applied (see Table 1). *Bradley* involved alleged sexual abuse of a child. Social consensus and public policy strongly favor protection of children. The court wrote that it was "clearly consistent with the stated public policy of this State to recognize tort liability where doing so will further the State's interest in protecting children from future abuse."[9]

Table 1
Factors in Determining a Duty to Warn[10]

- **foreseeability of harm**
- **special relationship between health care provider and patient**
- **public policy considerations:**[11]
    - **interest worthy of protection**
    - **degree of certainty the protected person suffered injury**
    - **moral blame of the conduct**
    - **economic burden**
    - **prevention of future harm**

Impact and Limitations of the *Bradley* decision

A decision by the Western District Court of Appeals in Missouri is only controlling in that jurisdiction. Missouri Courts in other jurisdictions are not required to follow this ruling to impose a duty to warn, but they may impose the duty because the holding is considered persuasive.

The *Bradley* opinion extends a duty to warn only to specific identifiable victims which is consistent with prior Missouri holdings but varies from the law in some other states.[12]

The *Bradley* case involved psychologists, but the court imposed the duty on "other health care professionals."[13] as well. The court did not specify which professionals are included in this group. Some states have imposed the duty to warn only on mental health professionals.[14] Other states extend the duty to warn to psychiatrists and therapists,[15] while other states extend the duty to an unlimited class of health care providers.[16]

The extent to which *Bradley* will influence courts in other Missouri jurisdictions is unclear. The

Continued on page 64

Continued from page 63

determinations of which professionals are obligated to warn and what constitutes a special relationship are also unclear.[17] Legislators may clarify these issues in future statutes, or subsequent case law may develop to flesh out the *Bradley* rule.

The duty to warn assumes that health care providers can assess their patient's propensity for violence. Mental health care professionals routinely determine the violent propensity of individuals in involuntary commitment and in release of hospitalized patients. Both the duty to warn and involuntary commitment hinge on legal parameters. Missouri psychiatrists and psychologists and the American Psychiatric Association and American Psychological Association indicate that no professional standards exist to articulate when commitment is appropriate or a duty to warn arises.[18] Medicine can articulate these issues for its professionals through development of professional standards. Courts are likely to utilize standards developed by professional organizations to decide cases on point.

While no clinical guidelines have been established to determine the dangerousness of a patient,[19] in Missouri, the mental health coordinator in civil detention proceedings, uses personal observation or investigation to determine whether a patient presents an imminent "likelihood of serious physical harm to him or herself or others."[20] Likelihood of serious physical harm is statutorily defined to include a...

"substantial risk that serious physical harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm."[21]

The mental health coordinator commits a patient only when the patient is an imminent threat to him or herself or others.

Commitment rests on an imminent threat of harm to self or others. Duty to warn arises when the "patient presents a serious danger of future violence."[22] While these standards are similar, they are not identical. Either may arise without the other. Health care providers have long been under a statutory duty to report child abuse[23] and elder abuse.[24] Depending upon the circumstances, both grounds for commitment and duties to warn and report may arise in the same case. The professional should carefully document his/her interventions.

Following *Bradley*, confidential patient information may be revealed only to the extent necessary to warn the victim. Critics argue that the existence of a duty to warn will dissuade persons from seeking treatment or interfere with their candor in treatment.

Advocates respond that therapists at the outset of treatment already disclose their duty to warn and to make disclosure of confidential information.[25] Since the decision of *Tarasoff* almost twenty years ago, the majority of states have imposed a duty to warn upon health care providers. None has constricted the duty following its establishment. This suggests that the cost to individuals of imposing the duty to warn is outweighed by the benefits to society.

Recommendations

The author makes the following recommendations in the wake of *Bradley v. Ray and Strnad*.[26]

1. Health care professionals should develop form disclosure statements for routine distribution to patients. Use of such forms would serve notice to patients regarding the limits of confidentiality and serve as a standard for such disclosure.

2. National professional organizations should (a) develop standards articulating those features of a patient history which are broadly accepted as reflecting likelihood of serious harm triggering a duty to warn, (b) develop ethical cannons dealing with confidentiality in the duty to report and duty to warn circumstances. By establishing such standards and cannons, the professions can guide their members and establish reasonable benchmarks for use by the courts.

3. State licensing boards should develop ethical rules on confidentiality and the duty to warn and should publish and distribute information for guidance. Duty to warn vis a vis breaching confidentiality is a slippery slope which should be articulated and broad-

cast by state licensing bodies to assist licensees and to protect the public.

4. State professional organizations should develop continuing education programs on when the duty to warn arises, how the case should be documented, and how the duty may be fulfilled. Continuing education is a common requirement for continued licensure or certification and programs are routinely provided by state organizations.

Conclusion

Society has a strong need for prevention of violence. The Missouri Court of Appeals has joined the majority of American jurisdictions in imposing a duty on health care professionals to warn identifiable third parties of potential violence by the patients. Public policy, foreseeability of harm, the cost of fulfilling the duty versus the amount of injury prevented, and the special relationship between health care professionals and patients and their victims have tipped the balance in favor of imposing this duty to warn on Missouri health care professionals.

References

[1] 904 S.W.2d 302 (Mo. App. W.D. 1995).

[2] 551 PP.2d 334 (Cal. 1976) (en banc).

[3] supra note 1 at 305. The petition alleges Mr. Pope sexually abused and assaulted K.P. by "forceful attempts at anal and vaginal intercourse, forced oral sex by and upon her, sodomy, masturbation and ejaculation upon [K.P.] and into her mouth, fondling and caressing of her to climax, single and multiple digital penetration of her vagina and rectum, forced insertion and use of a vibrator in her vagina, taking nude and sexually explicit photographs of her alone and with other children, and other acts of like nature."

[4] RSMo. §210.115 (1986); The Child Abuse Hotline is 800-392-3738.

[5] Norma Bradley's relationship to K.P. is unknown except that the court appointed her as K.P.'s next friend for purposes of litigation.

[6] The consequence of failure to report under RSMo. §210.115 (1986) is defined as a class A misdemeanor in RSMo. §210.165 (1986). The court declined to extend a civil remedy under the statute where a criminal penalty was provided.

[7] supra note 1 at 312.

[8] supra note 2 at 343.

[9] supra note 1 at 310.

[10] supra note 1 at 310.

[11] *Hoover's Dairy v. Mid-Am. Dairymen Inc./Special Products, Inc.* 700 S.W.2d 426 (Mo.banc 1985).

[12] *Sherrill v. Wilson*, 653 S.W.2d 661 (Mo. banc 1983). The Missouri Supreme Court declined to impose upon physicians at a state mental institution the duty to protect the general public. But see *Almonte v. New York Medical College*, 851 F.Supp. 34, 41 where the court extended the duty to "classes of potential victims" and *Naidu v. Laird*, 539 A.2d 1064, 1073 (Del.1988)(accord) where the class of potential victims was expanded to include anyone who could have been injured as a result of a patient's automobile accident while in a psychotic state.

[13] supra note 1 at 312.

[14] 16 Del.Code Ann. tit. 16, §5402 (1994) duty to warn imposed on mental health service providers; Idaho Code §§6-1902, 6-1903 (1994) and Mont.Code Ann. §§27-1-1102--1103 (1994) duty to warn imposed on mental health professionals.

[15] Cal.Civ.Code §43.92 (West 1995) duty to warn imposed on psychotherapists; Fla.Stat.Ann. §455.2415 (West 1994) duty to warn imposed on psychiatrist; La.Rev.Stat.Ann. §9.2800.2 (West 1993) duty to warn imposed on psychologist and psychiatrist; Utah Code Ann. §78-14a-102 (1994) duty to warn imposed on therapists.

[16] N.J.Stat.Ann. §2A:624-16 (West 1993) duty to warn imposed on health, mental health and counseling professions.

[17] supra note 1 at 311 "the relationship between psychologists and their patients is the kind of 'special' relationship on which liability can be based for failure to warn."

[18] Telephone interview with Bruce Harry, MD, Staff Psychiatrist at Biggs Forensic Center of Fulton State Hospital, Fulton, Missouri and Associate Professor of Psychiatry at the University of Missouri, School of Medicine, in Columbia, Missouri (Dec. 12, 1995); Danny Wedding, Professor of Psychiatry and Director Missouri Institute of Mental Heath, in St. Louis, Missouri, *Current Psychotherapies* (1995) and telephone interview (Dec. 7, 1995).

[19] *id.*

[20] RSMo. §632.300.2 (1986).

[21] RSMo. §632.005(9)(c)(1986).

[22] supra note 1 at 312.

[23] RSMo. §210.115 (1986); The Child Abuse Hotline is 800-392-3738.

[24] RSMo. §565.188 (1986); The Elderly Abuse Hotline is 800-392-0210.

[25] Danny Wedding, *Current Psychotherapies* 426 (1995).

[26] supra note 1.

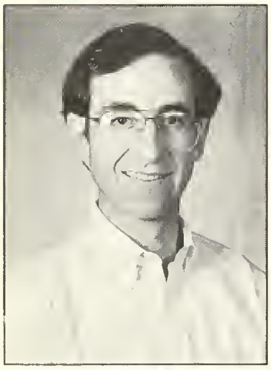
The Author

Crystal S. Seifert, is a third year law student at the University of Missouri-Columbia. She developed this article for a Seminar in Family Violence. She graduated from Northeast Missouri State University with a Bachelor of Arts in Political Science and has worked as a Juvenile Officer, Probation and Parole Officer, and as the Director of a Women's Shelter in Kirksville.

Hugh Stephenson Jr., MD

James J. Mongan, MD

Carole P. McArthur, MD



Hilton I. Price, MD

Hugh E. Stephenson Jr., MD, Growden Distinguished Professor of Surgery Emeritus, was elected president of the Surgical Caucus of the American Medical Association at the Interim Meeting of the House of Delegates in Washington, D.C. He also was appointed to serve another term as co-chair of the Liaison Committee on Medical Education, the accreditation agency for U.S. medical schools. He continues to serve on the American Medical Association Council on Medical Education, and is the immediate past chair.

James J. Mongan, MD, has been named president and chief operating officer of Massachusetts General Hospital, which is affiliated with Harvard Medical School. It is the oldest and largest teaching hospital in the country. He will be responsible for the daily management of the 900-bed academic facility and will help shape the institutional direction and strategy for the hospital as part of Partners HealthCare System. His new responsibilities begin in March.

Dr. Mongan served as executive director of Truman Medical Center Inc., since 1981, and dean of the University of Missouri-Kansas City School of Medicine in 1987. While at Truman, Dr. Mongan addressed many issues related to increasing patient volume and diminishing resources at the system's two hospitals, which are the largest health care providers for the indigent population of Jackson County. As medical school dean, he also led the 1989 merger of residency programs with Saint Luke's Hospital. The merger was a component of a long-range plan which was developed by Dr. Mongan to improve graduate training programs and to stabilize the medical school's financial standing.

Carole P. McArthur, MD, a Truman Medical Center resident, was recognized by the American Medical Association for her contributions to community service. Dr. McArthur was one of 40 honorees of the AMA/Glaxo Wellcome Inc. Leadership Award Program for resident physicians. The AMA established the Leadership Program in 1988 with a grant from pharmaceutical manufacturer Burroughs Wellcome Co. (now Glaxo Wellcome Inc.). The Program is designed to build ties between organized medicine and resident physicians who have displayed a commitment to community service. Awardees from across the U.S. attended the AMA Resident Physicians Section Interim Meeting held in Nov. 30 - Dec. 2, 1995, in Washington, D.C., and will have the opportunity to attend the June AMA Meeting in Chicago. Dr. McArthur gave more than 30 presentations on health care delivery to a variety of community groups during 1993 and 1994. She has been invited to lecture on a variety of topics including managed care at a local college and business school. She has also participated on health system reform discussion panels, submitted testimony to the state legislature, and participated on radio programs. Dr. McArthur is the president of Missouri Physicians for a National Health Program; board member of Missouri Citizen Action, which is a health reform advocacy group; a member of the Missouri Association for Social Welfare (MASW). In 1994, Dr. McArthur was keynote speaker at the annual conference for the MASW and was nominated for the University of Missouri's Outstanding Community Service Award. This year she received the Legislative Advocacy Award from the MASW.

Karen B. Webb, MD, MPH, has been appointed interim senior vice president and chief medical officer for SLUCare, the clinical services division of St. Louis University. As chief medical officer, Dr. Webb will serve as a liaison with SLUCare's network partners and managed care companies. Dr. Webb is involved in many facets of the development of SLUCare since 1994. She was elected faculty representative of the University Medical Group executive committee of the board of directors, chair of the managed care/billing subcommittee, a member of the marketing and bylaws committee, and of the chief operating officer search committee. Dr. Webb is professor of community and family medicine and director of the residency training program of preventive medicine/occupational and environmental medicine at St. Louis University School of Medicine. She also is assistant professor of community health at St. Louis University School of Public Health. Since 1983, she has been medical director of HealthLine Corporate Health Services, where she was instrumental in the development of that practice. Currently, HealthLine Corporate Health Services is the single largest provider of occupational medicine in St. Louis.

AMA PHYSICIAN'S RECOGNITION AWARDS

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs:

Herbert E. Arst, Kansas City
Daniel H. Frissell, Ste. Genevieve
Dale E. Jarka, Kansas City
Forrest H. Kendall, Kansas City
Susan L. Lee, Kansas City
Gary J. Meltz, St. Charles
Richard T. Padula, Kansas City
Charles R. Peterson, Osage Beach
Jeanne E. Leick Reiss, Kansas City
Charles W. VanWay, Kansas City

Hilton I. Price, MD, Christian Hospital-Northeast-Northwest Chief of Radiology, has been appointed President of the newly formed Midwest Radiological Associates, P.C. Twenty-eight radiologists from Alton Memorial Hospital, Christian Hospital Northeast-Northwest and Missouri Baptist Medical Center merged to form the new group.

Steve Gnatz, MD, associate professor and chair of the department of physical medicine and rehabilitation at the University of Missouri-Columbia, received the Outstanding Alumni Award from Baylor College of Medicine, Department of Physical Medicine and Rehabilitation at the American Academy of Physical Medicine and Rehabilitation's Annual Meeting held in Florida in November, 1995.

MSMA members **James Schell, MD,** a Boone County private practice physician in internal medicine; **Kenneth Weston, MD,** medical director of Family Health Care of Columbia; **Francis Corry, MD,** a general surgeon at Smith-Glynn-Callaway Clinic in Springfield; and, **Milton Fujita, MD,** chief executieve officer at Child Center of the Lady in St. Louis, were among the first class to graduate from the University of Missouri-Columbia's innovative master's program in health administration. The Executive Program enables health-care clinicians and administrators to coordinate their work responsibilities with graduate courses including financial management, organization structure and strategy, human resources management, clinical decision support systems, informatics, health policy and health law. Special emphasis is placed on managed care and its growing importance and impact on health care delivery in the U.S.

*MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to **Missouri Medicine**, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

In Memoriam

Robert B. Bristow, MD, 77, St. Joseph, Missouri, died December 2, 1995. Dr. Bristow was the third generation of medical doctors in his family. He graduated from the University of Missouri-Columbia in 1940 with degrees in chemistry, zoology and music. Dr. Bristow received his medical degree at St. Louis University in 1943. He completed an internship at Kansas City General Hospital. During World War II, Dr. Bristow served as a captain with the 88th Infantry. He then joined the 61st Station Air Force Hospital in Rome. In 1947, Dr. Bristow served his surgical residency at the Thompson-Knepper-Brumm Clinic in St. Joseph. He completed residency in urological surgery at Kansas City General Hospital and started his urology practice in St. Joseph. Dr. Bristow was a volunteer urologist for the Buchanan County Welfare Service for many decades, and was instructor of urology for the Missouri Methodist Hospital School of Nursing. He was chief of staff for Methodist Medical Center in 1956. Dr. Bristow was a member of the American College of Abdominal Surgeons, the American Urological Association, the Buchanan County Medical Society, the Missouri State Medical Association and the American Medical Association. He was honored in 1994 by the Missouri State Medical Association for over 50 years of medical practice.

John E. Brooks, MD, 61, Rogersville, Missouri, died December 4, 1995. Dr. Brooks received his medical degree at Faculty of Medicine Victoria University of Manchester, Manchester, England, in 1958. Dr. Brooks practiced in Africa and later did research and teaching at Washington University, St. Louis. Prior to his retirement, he practiced in Springfield, Missouri, with the Springfield Neurological Associates, Inc. He was a member of the Royal College of Physicians and the American Academy of Neurology.

John K. Caldwell, MD, 90, Kansas City, Missouri, died November 29, 1995. Dr. Caldwell graduated from the University of Missouri in 1928. He received his medical degree at the University of Pennsylvania in 1930. Dr. Caldwell completed his residency at Philadelphia General Hospital. In 1932, he returned to Kansas City to open practice in general medicine. During World War II he served as medical officer with the 45th (Thunderbird) Division of the Seventh Army in North Africa, Italy, France, and Germany. He spent the winter of 1944-45 at a battalion aide station on the front lines in Alsace. Immediately after the end of the war in Europe, he was charged with setting up medical facilities for displaced persons camps in Germany. Upon his return to Kansas City, Dr. Caldwell was associated with both Research and St. Joseph Hospitals and the Alfred Benjamin Clinic. Later, he practiced at Baptist Memorial Hospital and the present Research Hospital. He specialized in diabetes, and was instrumental in starting a summer camp for diabetic children. He served one year as president of the Missouri State Diabetic Association and was also a member of the Jackson County Medical Society, and the Missouri State Medical Association and the American Medical Association. He retired from active practice in 1984.

Oliver F. Duffy, MD, 89, Trenton, Missouri, died December 8, 1995. Dr. Duffy received his medical degree at the St. Louis University in 1932. After serving an internship at St. Louis City Hospital Number One, he returned to Trenton, Missouri in 1934 to start his general medicine and surgery practice. Among the medical firsts Dr. Duffy brought to Grundy County was the use of glucose, blood transfusion equipment, blood plasma and penicillin. In addition to his medical practice, he bought land north of Trenton and started the Goodview Angus Farms, where he resided. Dr. Duffy was a member of the Academy of International Medicine, the Grundy and Daviess Medical Society, the Missouri State Medical Association and the American Medical Association. In 1971, he was inducted into the Trenton Area Chamber of Commerce Hall of Fame.

Wallace H. Graham, MD, 85, Kansas City, Missouri, died January 4, 1996. Dr. Graham received his medical degree at the Creighton University in 1936. He received surgical training at the University of Vienna, University of Budapest, and the Royal College of Surgeon, Edinburgh, Scotland. Dr. Graham did an internship in Kansas City General Hospital and externships at Massachusetts General Hospital and Cook County Hospital. In 1935 he was commissioned a First Lieutenant in the U.S. Army. He was Chief of the 24th Evacuation Hospital Surgical Service during World War II combat from 1942 to 1945. He served with the 101st Airborne Division and saw combat in Normandy, Holland, Rhineland, and the Ardennes. He received the Bronze Star, Purple Heart, Distinguished Service Medal (Great Britain), Croix de Guerre (Belgium), Croix de Guerre with Palm (France), among other numerous military decorations and awards. General Graham gained national prominence in 1945, when he was assigned to be Chief of Surgery at Walter Reed Army Medical Center and was the personal White House physician to President Harry S. Truman. He was promoted to the grade of Major General, U.S. Air Force in 1951. Dr. Graham was a member of the Presidential Special Commission to Guatemala City, Nicaragua, and the Middle East. He was special assistant to the Surgeon General of the Air Force and was sent to surgically care for numerous head of state around the world between 1945 and 1953. Dr. Graham returned to private surgical practice with his father, J. W. Graham, MD, in 1953. He remained theTruman's family physician throughout Mr. and Mrs. Truman's lives. Dr. Graham was elected to the Hall of Fame at Creighton University and given the key to the city of Independence, Missouri. He was elected Distinguished Scholar of Central Missouri State University where he received his bachelor of arts degree. He was a fellow in the American College of Surgeons and International College of Surgeons. He was a member of the Royal Society of Medicine, the Metropolitan Medical Society of Greater Kansas City, the Missouri State Medical Association and the American Medical Association.

Harold R. Lyddon Jr., MD, 83, Kansas City, Missouri, died November 29, 1995. Dr. Lyddon graduated from the University of Missouri-Columbia in 1933. He received his medical degree at Washington University in 1937. During World War II, he was the Selective Service Physician for Harris County, Missouri. Dr. Lyddon was in private practice. He was a retired staff member of both Baptist and Research Hospitals. He was a member of the American Academy of Family Practice, the Missouri and Kansas City Academies of Family Practice, and the Missouri State Medical Association and the American Medical Association.

Albert "Al" May Jr., MD, 78, Poplar Bluff, Missouri, died December 7, 1995. Dr. May received his medical degree at Emory University in 1943. Following medical school he went into the U.S. Navy and interned at the Naval Hospital at Quantico, Virginia. He was assigned to the Marine Corps as a medical officer. During World War II he served with the Marines during the operation of Okinawa and Japan before returning to duty at the Naval Hospital where he started a training program in general surgery. Dr. May studied a year at the University of Illinois and completed residency at the Naval Hospital in Oakland, California, before going to the Philippines as senior medical officer from 1950-1952. From 1952-1955, he worked at the Naval Hospital in Jacksonville, Florida. He resigned from the Navy after 12 years of service and went to Poplar Bluff. He practiced medicine for 43 years, 31 years of practice in Poplar Bluff. Dr. May arrived at Lucy Lee and McPheeters Clinic in 1955. He was one of four doctors and the only surgeon practicing there. In addition to serving as the hospital's chief surgeon, Dr. May also served on the hospital board. He served as board chair for a number of years. The Lucy Lee Healthcare System's Surgicenter for outpatient surgery and procedures was renamed in his honor last July. He retired from Lucy Lee in 1986, but continued to serve on the hospital board until 1994. Dr. May had also served as a consultant in general surgery at the John J. Pershing VA Medical Center. He was a member of the American Society of Abdominal Surgeons, the Southern Medical Association, the Butler-Wayne-Ripley Carter County Medical Society, and the Missouri State Medical Association and the American Medical Association. He was a fellow of the American College of Surgeons and a member of the Missouri chapter.

John P. Roberts, MD, 76, St. Louis, Missouri, died January 27, 1996. Dr. Roberts received his medical degree at Washington University in 1945. He was on the medical staffs of area railroads, including the old Frisco and the former Missouri Pacific. He retired in 1991. Dr. Roberts turned a fascination for trains into a 40-year effort to preserve them. In 1946, Dr. Roberts was one of the founders of the St. Louis Railway Historical Society. The museum next to the Union Pacific main line just west of Kirkwood, exhibits 250 locomotives and railroad cars. The steam collection is considered one of the largest exhibits of old railroad equipment in the country. Dr. Roberts remained a director of the Transport Museum Association until 1984. A train shed at the museum is named after him.

The changing face of Medicare peer review
Quality improvement forms the key to better care

John Sotham, MPCRF Education Coordinator

The quality revolution has reshaped thousands of American and international businesses, and has brought greater efficiency, productivity and lowered costs.

The concepts of quality improvement are simple: Rather than strictly monitoring the results of the processes that produce goods and services, the key is to focus and improve the processes themselves. Applied to the health care industry, this change in thinking has resulted in continuous quality improvement, or CQI, which has already had a lasting impact on patient care.

The quality revolution has also reshaped the ways in which the Missouri Patient Care Review Foundation (MPCRF) monitors the care delivered to Missouri Medicare beneficiaries. Peer review organizations (PROs) like MPCRF, mandated by Congress to oversee the care delivered to Medicare beneficiaries in each state, used to rely primarily on random case review, whereby a team of doctors and nurses reviewed thousands of Medicare case records every year.

As noted in a May 1995 *Physician's Weekly* article, the old peer review system was roundly criticized by the medical community for being a program based solely on the zealous pursuit of a few physicians engaging in questionable practices. Now, instead of focusing on the negative, says HCFA's Director of Quality Improvement Programs, Michael McMullan, PROs will concentrate on improving quality. Such organizations are now termed quality improvement/peer review organizations (QIO/PROs) to denote their change in philosophy.

The focus of this transformation is the Health Care Quality Improvement Program (HCQIP), a new program to help providers improve their care by using the principles of quality improvement. Now, HCQIP staff analyze large segments of Medicare claims data and identify potential areas where care can be improved. Such analysis often requires the retrieval of additional clinical information directly from medical records. HCQIP staff then engage hospitals and physicians in collaborative projects that focus on specific clinical issues. After baseline analysis, MPCRF works with each participating facility to develop an individualized action plan that maps out how improvements will be made. Measurements are then taken to determine the plan's effectiveness.

Heading HCQIP on behalf of MPCRF is Gary Fortune, DO, MPH, Principal Clinical Coordinator. Dr. Fortune provides leadership in identifying areas of medical consensus and in bridging clinical issues with biostatistical and epidemiologic techniques fundamental to health care quality improvement. "Getting physician buy-in is a key aspect to making the process work," Dr. Fortune says. "If the administration and physicians aren't on the same sheet of music in looking at the total continuum of care, it really impairs the potential for improving quality of care. The burden is not just on physicians. Facilities must foster comprehensive improvement efforts that cross interdepartmental lines," he says.

MPCRF's extensive data analysis capabilities are also used in community outreach efforts, which are partnered with clinical cooperative quality improvement projects to form a coordinated effort to impact the overall health of Medicare beneficiaries. The Foundation's community outreach services include educational projects such as ongoing influenza immunization and mammography campaigns in addition to case review capability, an important part of its mission to respond to Medicare beneficiary concerns.

HCQIP staff continually examine clinical literature as well as solicit new topic ideas from the provider community to find new opportunities to apply quality improvement principles. Projects focus on such subjects as community acquired pneumonia, atrial fibrillation and stroke prevention, pressure ulcer prediction and prevention, perioperative antibiotics administration, and the utilization of right heart catheterization. One of the most exciting current HCQIP efforts, the Cooperative Cardiovascular Project (CCP), is a national effort by HCFA to analyze treatment practices for AMI patients and to improve outcomes. Such projects show the tremendous potential for large-scale coordinated quality improvement initiatives to benefit thousands of patients.

"One of the most important long-term benefits of the program is the ability to produce enduring change," says Dan Jaco, MPCRF Chief Executive Officer. "The old approach, which was centered on quality assurance and inspection, was conducive to short term compliance, but not long term behavioral change." Jaco hopes that by participating in HCQIP projects, hospitals will be able to use newly learned quality improvement principles on a variety of internal projects. However, there is always value in the external perspective. "All the tools are out there for any hospital that wants to internalize them, but it's always helpful for someone to come in from the outside to facilitate interdepartmental dialogue and to help people get the broad view," he says. "We need to be helping hospitals develop those skills so they can foster quality improvement internally."

Jaco is optimistic about the future of HCQIP and its potential to affect change in practice patterns statewide. "In the long run, the program is going to produce higher quality care than the inspection mode," he says. "And, I think our potential extends well beyond just Medicare."

To find out more about MPCRF cooperative projects, call the Provider Hotline: 1-800-735-6776. Next month, we will detail HCQIP project and their outcomes.

Missouri Patient Care Review Foundation (MPCRF) Current Health Care Quality Improvement Program (HCQIP) Projects

Developmental:

- Atrial Fibrillation and Stroke Prevention
- Cooperative Cardiovascular Project
- Diabetes Mellitus - ACE Inhibitor

Implemented:

- Community-Acquired Pneumonia III
- Perioperative Antibiotic
- Ambulatory Surgery History & Physical Documentation
- Discharge Planning Congestive Heart Failure
- Tuberculosis Education

Post-Project Monitoring:

- Influenza Immunization
- Blood Component
- Right Heart Catheterization
- Medication Use
- Pressure Ulcer Prediction and Prevention

Complete:

- Community-Acquired Pneumonia Length-of-Stay
- Community-Acquired Pneumonia Mortality
- DRG Cooperative
- Intermittent Positive Pressure Breathing
- Radical Prostatectomy

HCQIP Cooperative Project Process

- **MPCRF solicits, discusses and generates topic ideas for a cooperative project**
- **Perform literature search**
- **Select quality indicators that measure patterns of care that can be improved**
- **Develop project data collection (PDC) tool to measure quality indicators**
- **Perform investigational data abstraction and analysis**
- **Present project background indicators and results of investigational PDC analysis to providers**
- **Collaborate with providers and seek commitment to develop an improvement plan**
- **Perform baseline abstraction and/or evaluation**
- **Feedback results of baseline abstraction to provider who uses information to write improvement plan**
- **Allow time for implementation of improvement plan**
- **Collect and measure indicators intraproject (provider)**
- **Remeasure quality indicators to assess improvement (MPCRF)**
- **Feedback results**

Mid-Missouri Medical Care

Tim Steffl, Executive Director

Mid-Missouri Medical Care (MMMC) is a 100% physician-owned independent practice association (IPA) based in Jefferson City and the greater Lake of the Ozarks. MMMC's business is to allow physicians to remain independent yet act as a large multi-specialty group.

Our goal is twofold. The first goal is to enhance the role of the practicing physician as a driving force in the managed care environment. The second goal is to create a community-based health care product where everyone in the community is involved.

In order to satisfy these goals we have set up community advisory boards that consist of business and civic leaders in Jefferson City and Lake of the Ozarks. The board members used their experiences, good and bad, with their current insurance company to make a list of requirements for the community product. We used their ideas along with the input of physicians to formulate this product.

One of the needs of our community is for small businesses to have the opportunity to participate in group insurance plans. We made it a requirement to offer this product to all businesses that have three or more employees.

After gathering a list of all of the requirements we took the plan to insurance companies. We asked them to work with our network of 140 physicians, including 11 physicians employed of Captial Regional Medical Center, and incorporate our ideas in their health plan to market to the community. We currently have contracts with many insurance companies in both fee-for-services and risk contracts using the basic guidelines set forth by the community advisory boards.

Because pharmacy is a large part of any insurance plan, we have decided to partner with the Missouri Pharmacy Association (MPA). MPA has agreed to provide us their network of locally owned pharmacies throughout the state of Missouri. They have told us that they can be cost competitive with the mail order companies and chain drug stores. They will also help us to develop a community drug formulary that will be used by all physicians in our organization.

Often when we are in negotiation with payers they want a one-stop shop of health care providers. So, we went out and recruited non-physician health care providers to become members at non-shareholder (non-voting) status. With a robust panel of healthcare providers we have much more leverage in all negotiations.

Continued on page 78

Surprisingly, two of the more innovatively organized physician practices are not in Kansas City or St. Louis. The Jefferson City Medical Group (JCMG) and Mid-Missouri Medical Care (MMMC) represent over 200 physicians in the Jefferson City area.

Physician Organizations (POs) allow physicians to make all the important decisions about their practices, and also be responsive to businesses, government, and insurance companies.

Unified physicians can defend themselves from "divide and conquer" strategies of hospitals and payers. By creating a PO like the two profiled, physicians can position themselves for contracting with managed care organizations (MCOs). Groups of this magnitude have fewer problems contracting with MCOs than do physicians who contract individually.

They also have the advantages of offering comprehensive services and having a centralized management information system.

Both of these groups along with Renaissance Healthcare Partners, Inc. of Kansas City and Missouri State Medical Services, Inc., will participate in a panel discussion at the MSMA Annual Convention, Saturday, April 13 at Tan-Tar-A Resort, Lake of the Ozarks (See details on page 57).

Jefferson City Medical Group

Joseph G. Gubbels, Executive Director

Jefferson City Medical Group (JCMG) is the first independent, fully integrated, multi-specialty medical group in central Missouri, formed on the principles of delivering high quality, comprehensive, cost effective health care. JCMG was formed in 1993 by a merger between a nine member internal medicine group and a two member family practice group. In the ensuing two and a half years, we have grown to a 35 physician group, representing 15 specialties. Our long-term goal is to continue to be a primary care based, multi-specialty group.

JCMG has been proactive in partnering with managed care organizations to supply and deliver cost effective, quality care; something our patients and local businesses have requested of us. JCMG entered into relationships with hospitals, other physicians and managed care organizations to guarantee the efficient delivery of healthcare in central Missouri.

The group's success comes from a strategy of management efficiencies, physician cooperation, a proactive relationship with managed care organizations and local businesses, physician leadership, and a commitment to re-engineering healthcare management and delivery in both the outpatient and inpatient arenas. Some of the re-engineering projects include:

- Successful implementation of hospital and outpatient clinical pathways have allowed us to streamline inpatient and outpatient care. The sharing of one common information system among all the divisions of the group will allow us, in the next 12 to 15 months, to efficiently track patient encounters, consultations and outcomes;
- Successful implementation of several outpatient ancillary services, including home infusion, office infusion, durable medical equipment, laboratory, radiology, pre-operative teaching classes, etc.;
- Successful recruitment of both primary care and specialty physicians in our community, which allows us to care for more of our patients locally; and,
- Adoption of the National Committee on Quality Assurance (NCQA) Health Plan Employer Data Information System (HEDIS).

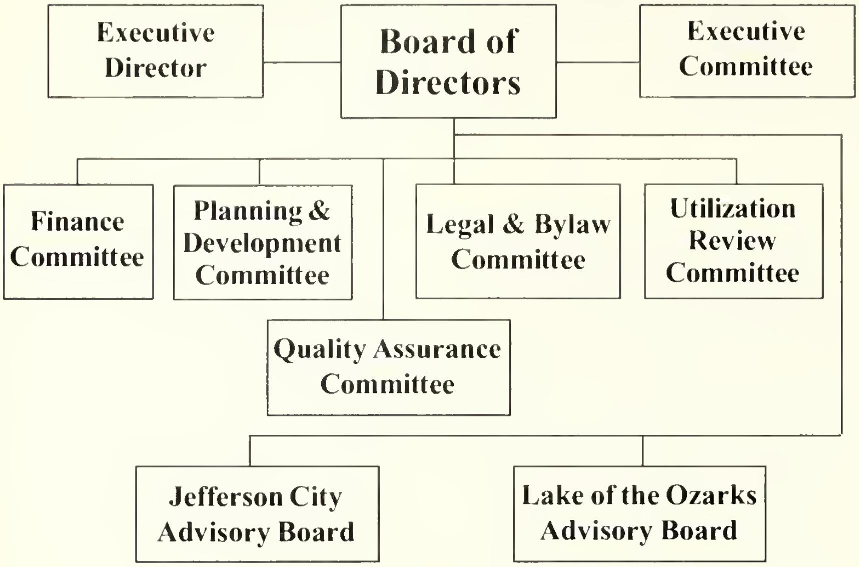
The HEDIS program will allow JCMG to be a pioneer in central Missouri with outpatient medical services. With this integrated performance measurement and assessment system JCMG will better assess childhood immunization rates, cholesterol screening, mammography screening, Pap smears, prenatal care, and chronic disease (asthma, diabetes, etc.) care.

Just as important to JCMG are the access and satisfaction programs HEDIS offers. JCMG is building programs to assess and improve patient satisfaction rates, ambulatory care utilization patterns, and outpatient drug utilization protocols, to name a few. JCMG then plans to blend these outpatient/clinic indicators with current inpatient programs to begin development of outcomes data programs and analyses. When healthcare providers can manage their patients through outcomes data and programs, we will raise our holistic patient care delivery to a higher quantum.

The Jefferson City Medical Group emphasizes medical care through primary care avenues. Our family physicians enjoy offering a sophisticated and complete array of services, including pediatrics, adolescent medicine, general medicine, preventative care, cancer screening, acute care, geriatric care, and education to patients of all ages. The gatekeeper model we use with many of our HMO contracts allows for quick access to and assessment of patients needs. With the emphasis on patient education and preventative care, our family physicians believe they can make a difference in the lives of central Missourians. These

Continued on page 78

MMMC Organizational Chart


Executive Director
Board of Directors
Executive Committee
Finance Committee
Planning & Development Committee
Legal & Bylaw Committee
Utilization Review Committee
Quality Assurance Committee
Jefferson City Advisory Board
Lake of the Ozarks Advisory Board

MMMC - Continued from page 76

Besides negotiating contracts, another service we provide is a group purchasing organization (GPO). With 140 members in our group, we found that most suppliers will give larger discounts to us than they would to the individual practitioner. Our GPO offers discounts on everything from medical services and supplies to long distance and travel for any physician that wishes to participate. We have tried to keep our suppliers local whenever possible.

MSO-MMMC has been working with five other IPAs in central Missouri to form a larger physician owned organization. The organization is called Synergy Health Systems (SHS) and will provide a buffet of services to each IPA, including: IPA management, billing, practice management, clinic construction and facilities management, billing, practice management, group purchasing, and many others. SHS will also help physicians in other areas of the state start physician organizations that will include but not be limited to IPAs, Group Practice Without Walls and multi-specialty clinics. SHS has 331 physicians. We believe a larger provider panel covering many counties will give physicians much more bargaining power than a stand alone IPA or group.

Synergy is equally owned by each IPA. Any group that joins in the future will have the same opportunity for equity ownership. We believe that it is important for physicians to be the focal point in any health care delivery system - creating one of the organizations mentioned above is certainly the way to start.

JCMG - Continued from page 77

physicians are the foundation upon which JCMG is built.

We believe our women's health services will be one of the growth areas in our future. Our six obstetrician/gynecologists offer comprehensive care to the women in our area. As we develop programs in post-menopausal health care, worker's compensation/business health services for the women of child bearing age, and adolescent female care, the Women's Clinic division will help anchor the primary care base JCMG holds so dear to their growth and success.

Technology is such an important aspect of medicine today, and while JCMG has many specialists covering many areas, we see growth potential in cardiology and oncology. These are two services that, until 8 to 10 years ago, were not offered in a comprehensive way by our service area. We are proud of the growth and accomplishments the clinic has made in these areas. We currently have locally accessible, full service programs in these two areas.

In the future, the Jefferson City Medical Group hopes to grow both their clinical and management services into the surrounding counties of central Missouri. Our proactive relationships with managed care organizations, recruitment strategies, outpatient outcomes management, and professional management team should continue to nurture our success.

This article is in response to MSMA members' desire for more information about managed care. If you have managed care information of interest to *Missouri Medicine* readers, please submit it to: Patrick Mills, MBA, CPA, MSMA Director of Health Care Finance, PO Box 1028, Jefferson City, MO 65102; Fax: (573)636-8552.

Revenue and Percentages of Medical Expense and Administrative Expense for Missouri HMOs, 1992-1994

Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

	1994			1993			1992		
Missouri HMO	**Revenue**	**Med.**	**Admin.**	**Revenue**	**Med.**	**Admin.**	**Revenue**	**Med.**	**Admin.**
Prucare of KC	1,816,523,500	83%	15%	1,533,860,000	79%	13%	1,274,750,000	82%	11%
Humana Health Plan	915,890,430	82%	13%	844,103,468	82%	13%	902,114,217	82%	12%
Gencare Health Systems	246,070,601	77%	10%	193,360,352	78%	11%	153,806,095	79%	11%
Group Health	200,890,738	87%	12%	178,982,343	89%	11%	149,306,901	85%	10%
Humana Kansas City	170,349,760	84%	13%	162,843,781	83%	14%	118,995,991	105%	14%
Truman Medical Center	157,201,868	72%	15%	154,291,155	69%	14%	11,516,607	106%	2%
PHP of Greater St. Louis	150,553,421	81%	17%	103,646,914	80%	18%	67,218,806	81%	17%
Bluechoice	95,224,175	70%	16%	88,590,685	67%	17%	81,064,580	71%	17%
Total Health Care	88,314,767	71%	10%	86,067,511	83%	7%	89,680,822	78%	7%
Kaiser of KC	70,104,239	79%	19%	69,645,759	80%	16%	62,646,780	82%	18%
Partners	60,896,284	86%	12%	37,918,728	86%	13%	30,758,893	83%	13%
CIGNA Healthplan of KS/MO	54,169,139	72%	28%	128,023,535	84%	15%	140,187,750	86%	13%
Exclusive Healthcare (KC)	52,893,471	96%	14%	37,252,529	89%	13%	28,794,733	86%	12%
Metlife Healthcare (St.L)	47,913,942	75%	16%	41,102,970	78%	11%	47,493,203	81%	12%
BlueAdvantage	45,952,985	88%	11%	27,924,9511	10%	13%	8,417,5971	25%	54%
Principal of KC	42,749,840	76%	21%	40,507,111	76%	16%	33,345,819	77%	14%
BlueCare	27,699,209	66%	9%	31,335,693	71%	9%	32,003,691	84%	10%
Citizens Advantage (Bolivar)	24,836,265	95%	5%						
CIGNA Healthplan (St.L)	19,871,005	51%	40%	18,468,595	63%	29%	28,116,429	80%	15%
Metlife of KC	10,189,962	85%	16%	8,651,222	79%	11%	7,853,468	79%	11%
BMA Selectcare, Inc.	8,929,188	77%	20%	6,412,834	81%	20%	3,267,336	79%	19%
HealthNet	6,236,896	82%	54%	46,288			2,663,100	83%	55%
HealthLink	4,337,848	83%	32%	637,914	84%	146%			
AVERAGE	187,730,414	79%	18%	172,439,743	80%	20%	155,904,896	85%	17%
Minimum	4,337,848	51%	5%	46,288	63%	21%	99,962,641	86%	17%
Maximum	1,816,523,500	96%	54%	1,533,860,000	110%	21%	57,744,137	86%	17%

Source: Missouri Department of Insurance

Medical Education: Market Forces at Work

Ted Groshong, MD, Associate Dean for Medical Education
University of Missouri-Columbia School of Medicine

Physicians practicing in Missouri have encountered enormous change in the way health care is delivered. The changing practice of medicine has begun to influence young people who are planning a career in medicine. While applications for medical school reached an all-time high for the class beginning in 1995,[1] applications for admission to U.S. medical schools in 1996 have leveled off.[2]

In the May 1993 issue of *Missouri Medicine*, we reviewed the demographics of medical school applications. A major increase in applicants had been identified over the previous three years. This increase continued dramatically for the next two years (Fig 1).

Academic institutions were subjected to severe pressures to increase class size. In spite of those pressures, however, the number of positions for first-year students in U.S. medical schools remain stable. As a result, the ratio of applicants to matriculants increased from 1.67 in 1988 (the Nadir in applicant pool) to 2.86 in 1995. A similar increase in applications from residents of Missouri has been noted at MU (Fig 2).

This increase in interest occurred against a background in which a medical career was not necessarily becoming more attractive from the perspective of practicing physicians. Thus, it was difficult to explain the continuing increase in interest in medicine.

Various explanations had been offered, including an increase in altruism on the part of young people, a lack of understanding on the part of matriculants of the constraints physicians were experiencing in their ability to provide health care, or simply that those factors causing distress for practicing physicians such as a desire for personal independence, are not so significant for young people today.[4]

One explanation, advanced by Dr. Donald Kassebaum, Vice-President of the Association of American Medical Colleges, was a simple matter of economics. With employment opportunities scarce in engineering and science, potential students were drawn into a medical career where employment opportunities were seemingly inexhaustible.[5]

This theory has received credence, not only with the temporal association of a drop-off in medical school applications coincident with projections of health manpower surplus, but additionally, with changes in student's choices of fields for graduate medical education.

Several reports have recently been published, and received noteriety, projecting just such a surplus.[6] Of particular concern has been the potential for an excess supply of specialists in a variety of fields; a physician surplus projected to exceed 125,000 by the year 2000.

Conversely, a shortage in primary care specialists has been projected by many authorities. This shortage, however, is only expected to number 20,000 physicians, and even this number has been disputed.[7]

As a result of these projections, there has been a surge of interest among medical students in careers in primary care, and in family practice in particular. The 1995 Residency Match demonstrated that trend.[8] Family practice (and pediatrics) showed a substantial increase in filled positions. Over 70% of positions offered in family practice in 1995 filled with U.S. seniors, in contrast to only 56% in 1992, in spite of the fact that there was an increase of more than 20% in offered positions. Similiarly, 73% of pediatric positions filled with U.S. seniors in contrast to 64% in 1992. There was no increase in positions offered in pediatrics. Over half of all U.S. medical graduates entering residencies at the first-year level were matched in fields potentially making them available for primary care.[9]

Residency positions in speciality training programs showed a remarkable, though variable, loss of popularity. Many programs in anesthesiology, once among the most competitive, experienced an enormous drop in popularity with only 37% of offered positions being filled with U.S. seniors. This is in contrast to the fact that more than two-thirds of positions were similiarly filled in 1992.[8] The residency match followed a front-page article in the *Wall Street Journal* delineating the experience of a recent anesthesiology graduate of a California program, and his inability to find a full-time position in his field.[10] Similar difficulties in filling post-graduate positions are being experienced in Cardiology, Gastroenterology, and Pulmonary Medicine. While

Continued on page 74

Figure 1. Number of Applicants & Matriculants

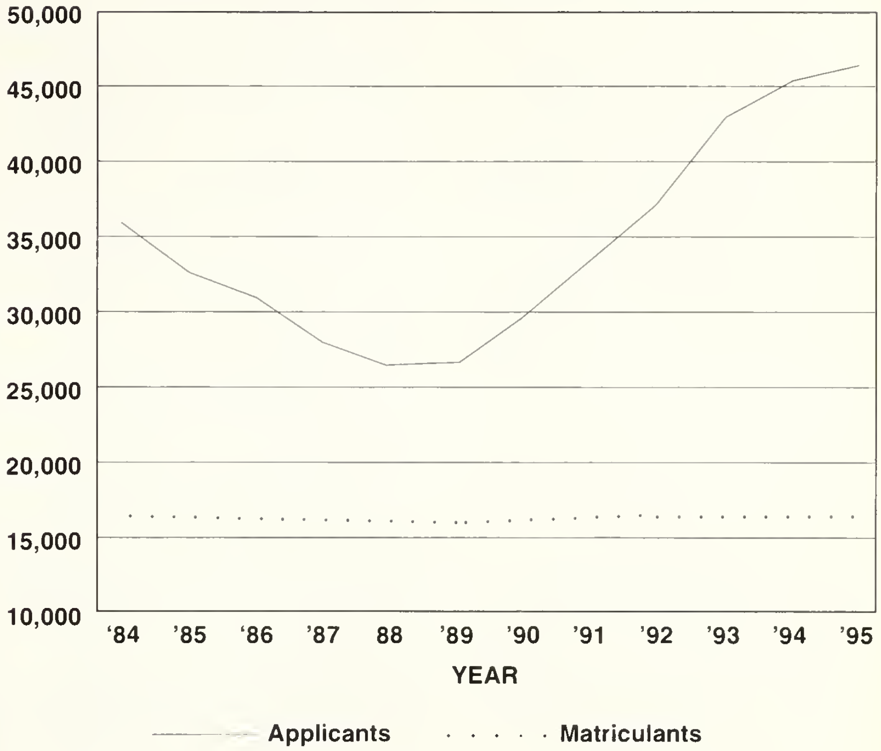
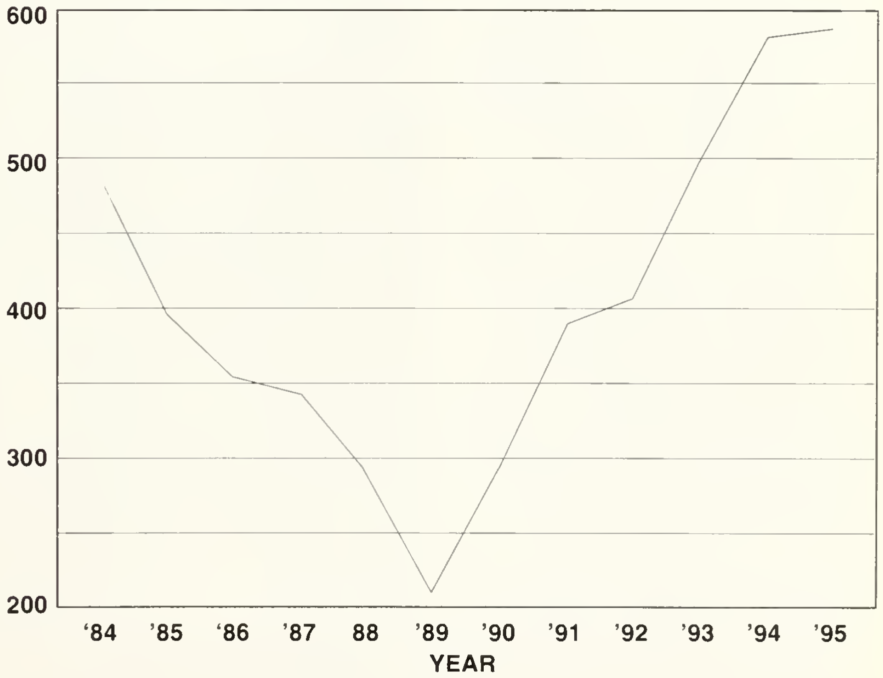


Figure 2. Applicants to MU from Missouri Residents



Continued from page 73

residency programs in Ophthalmology, Radiology, and Orthopaedics continue to fill, competition for those positions has been substantially reduced.

Regardless of over-all health manpower projections, there continues to be a concern for physician supply in under-served areas. Minority physicians have been shown to disproportionately provide care to minority communities. However, there has not been a substantial increase in the number of applicants from under represented minority groups applying to medical school. Between 1994 and 1995, for example, there was a 5% drop in African-American males and a modest .6% increase in African-American women applying to medical schools.[1]

Similiarly, while statistics are much less reliable, there is no clear indication that an increased number of people from rural areas are attempting to enter medicine, though geographically many rural areas are as much in health manpower undersupply as intercities.[11]

In spite of this, it is becoming increasingly clear that an important factor influencing graduate medical education will be potential changes in financing.

Currently, most of the cost of graduate medical education is being provided by the Federal Government through designated portions of the Medicare (and to a lesser extent, Medicaid) appropriations. Hospitals are specifically reimbursed for the costs of Graduate Medical Education under Direct Medical Education benefits based upon the number of residents per hospital bed, the percentage of hospitalized patients who are supported by Medicare, and the salary and benefit costs to the teaching hospitals.

Congress, in an attempt to control Medicare expenditures, has begun the process of reducing these DME payments by financing residents only until they have achieved adequate training for initial board certification, or five years; whichever occurs earlier.

The second means of support, Indirect Medical Education costs, theoretically provide funding for those costs incurred on the part of teaching hospitals by reason of their educational missions. It is provided as a percentage increase in DRG reimbursement. That percentage is slated for reduction, the amount to be determined by the final budget to which the Congress and the President can concur.

One proposal, which has received wide-spread credence, has been to reduce funding for graduate medical education to 110% of graduating U.S. medical students.[6] Currently, approximately 40% of physicians in graduate medical education are filled with international medical graduates. If, as is reasoned, a surplus in physicians is forecast, perhaps the Federal Government should cease providing financial support for training these physicians if they are to remain in the United States.

It is becoming increasingly clear that market forces are having a major effect on medical education. Changes in the medical market place combined with efforts on the Federal level to reduce expenditures, are likely to have a dramatic effect on medical education over the next decade.

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The Nation's Physician Workforce: Options for Balancing Supply and Requirements

A report from the Institute of Medicine's Committee on the U.S. Physician Supply

According to the Institute of Medicine, immediate steps are need to reduce the overall number of physicians-in-training the U.S., while protecting access to health care for underserved populations. A recently released report calls for a freeze on class sizes in medical schools, recommends that no new medical schools be opened, and says the federal government should reduce the number of medical residency positions it funds.

Committee Co-Chair Don Detmer, senior vice president, University ofVirginia, Charlottesville, said, "In the past two decades, the number of physicians has grown 1.5 times the rate of the general population, increasing from 150 to 100,000 people in 1970 to 245 in 1992." He added, "Yet for all this growth we have seen too little improvement in the cost or quality of, or access to, health care. Having more physicians has not meant having more care of the right kind, at the right place, or at the rights cost."

The committee found problems, not benefits, from a significant oversupply of physicians. Studies have shown that in a fee-for-service practice, increasing the number of doctors can lead to higher aggregate health care costs. Left unchecked, the rising number of physicians may crowd the physician labor market to the point where promising U.S. students might even forego a career in medicine, the report says.

Finding a perfect balance between physician supply and societal needs is probably an unachievable goal. However, the prospect that an "appreciable surplus" of physicians will arise in coming years means that action is needed now to bring the demand and supply into better balance.

"Clearly, if the nation had to choose today between too many physicians and too few, it would prefer an excess, but we think there is little to be gained from a huge imbalance," said Co-Chair Neal Vanselow, professor of medicine, Tulane University, New Orleans. "Producing more physicians than the nation requires is a waste of both human resources and the federal resources spent on residency training."

The largest growth in the physician work force has been in the number of international medical graduates (IMGs) coming to the U.S. for government-funded residency training, and eventually, to practice. From 1988 to 1993, the total number of IMGs in residency or fellowship training increased by 80% - from 12,433 to 22,706 - while the number of U.S. graduates held steady at about 17,500. Of the IMGs who come to the U.S. for residency, 75% remain here to practice.

The link between payments for health services and for graduate medical training needs to be broken. Under today's system of funding, hospitals are compensated by the federal government for each resident they train. The system should be revamped to bring the total number of positions funded closer to the number of graduates from U.S. medical schools. With no cap on the number of residency positions funded, there is an incentive for cash-strapped hospitals to increase residency positions in order to bring in more federal funds.

Hospitals in the inner city and rural areas that have trouble attracting U.S.-educated doctors for residency training depend on an influx of IMGs and the funding they bring to help provide care for underinsured, uninsured, and poor populations. According to the committee, to make up for the loss of income and care that a cut in residency positions could bring in those cases, the federal government should develop a system of "replacement funding" that directly supports the health care of needy populations, rather than funneling such support through residency training, Replacement funding would enable hospitals to use federal support more efficiently by catering spending decisions to patients' needs. Some hospitals may elect, for example, to replace resident physicians with nurse practitioners and physician assistants.

The committee stressed that the demand for doctors will remain unpredictable as managed care continues to grow in relation to the traditional fee-for-service delivery system. In recognition of the fact that a record number of people are still applying to medical school in this country, despite impending oversupply, the committee recommended that up-to-date information on career opportunities in medicine be made available to prospective medical schools. The report also recommends that the U.S. Department of Health and Human Services (DHHS) fund research on physician work-force issues, including the relationships among physician supply and health care costs, quality, and access.

The study was funded by the National Research Council with support from DHHS. The Institute of Medicine is a private, non-profit organization that provides health policy advice under a congressional charter granted to the National Academy of Sciences.

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Will Managed Care Collapse at the Hands of the Civil Justice System? ERISA Protection May End

Arthur Gale, MD, St. Louis

Managed care has taken the country by storm. Companies are enrolling their employees almost exclusively in managed care plans. State governments have embraced managed care as the solution to the Medicaid cost problem. Managed care is being touted as the solution to the Medicare trust fund financial crisis. Managed care companies have achieved enormous penetration of the market and spectacular financial success.

But the sun may be setting on the for-profit HMOs. Dark clouds are gathering for managed care organizations which use financial incentives for physicians in order to control costs.

The news media have reported stories about substandard care and perverse financial incentives which are inherent in gatekeeper HMOs. The HMO industry is not threatened by these reports. It knows that it is not employees, but corporations looking for the lowest price who purchase health insurance. Managed care knows there will always be a buyer for their product.

Of greater concern to the managed care insurance industry is the awakening of the civil justice system to the potential harm which can occur to patients from the conflicts of interest present in capitation and withholds. Through lawsuits the civil justice system can cost managed care money. Big money.

For the first time, instances where HMO strategies to save money collide with the patient's right to receive quality of care have come under the scrutiny of the law.

New developments in the law will for the first time make managed care accountable for its actions. According to a leading expert on insurance company liability, we are on the threshold of another malpractice crisis. This crisis will not only involve physicians but also the managed care industry and the owners of large and small businesses who self insure. Such a crisis could sever the link between employment and health care which is unique to the United States.

In 1974 Congress passed a law called ERISA, the Employee Retirement Income Security Act, which covers all company self insured health plans. In addition it covers labor unions and professional associations. From 60 to 85% of all employed Americans are covered under ERISA. In enacting this law Congress forgot to write substantive legislation covering insurance company medical malpractice. Since ERISA preempts state regulations, the health insurance industry is essentially unregulated and unaccountable to the public. This law more than any other cause has been responsible for the excesses of managed care.

A famous case, *Corcoran vs. United Health Care Inc.*, established the legal precedent which has allowed managed care to dodge the malpractice suit bullet. Florence Corcoran suffered complications of pregnancy. The utilization review board of her insurance company told her that they would not pay for further hospitalization and that she would have to go home and be attended by a nurse. Against the advice of her obstetrician she was discharged. At home the fetus went into distress and died. Corcoran sued the insurance company.

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Under ERISA the judge, acknowledging the injustice of his decision, had no recourse but to deny Corcoran redress of her grievance.

The new buzzword for health care delivery is free market economics. The credo of the free market is based on a Darwinian "state of nature" concept which can best be described as unfettered competition and the survival of the fittest. The advocates of a totally unfettered free market proudly define its operation as amoral. Managed care subscribes to that credo. The founders of our nation had a different credo. Managed care is going to be taught a hard lesson about that credo.

Managed care is already learning lessons about limits to its authority. In Arizona an HMO utilization review physician denied authorization for a cholecystectomy to an enrollee in the plan. The patient, who had right upper quadrant pain, went ahead and had the cholecystectomy anyway. The pathology report revealed cholecystitis. The operating surgeon then reported the utilization review physician to the state board of registration. After evaluating the case the board of registration sent the HMO physician a letter of concern.

The HMO said the board of registration had no authority in the matter because the decision was an internal administrative business matter. The HMO then made the mistake of appealing the board's decision in court. The case went all the way to the Arizona Supreme Court which ruled that the Board did have the authority in this case.

Now a precedent has been established that utilization review physicians are accountable to the State Boards of Registration for utilization review decisions. Utilization review physicians will have to think twice before issuing denials for care. Their license to practice medicine could be in jeopardy.

Now a precedent has been established that utilization review physicians are accountable to the State Boards of Registration for utilization review decisions. Utilization review physicians will have to think twice before issuing denials for care. Their license to practice medicine could be in jeopardy. The Arizona Supreme Court decision could also have far reaching effects on managed care's bottom line.

Consumer organizations, members of Congress, and the National Association of Insurance Commissioners have all tried to repeal ERISA. AMA policy supports repeal of ERISA. Nevertheless, efforts to repeal this unfair law have been unsuccessful. The opposition of the insurance and business lobbies has been too strong.

But the civil justice system can and eventually does work. In 1995, the 3rd and 10th circuit courts recognized the basic injustice and unfairness of ERISA *Dukes vs. U.S. Health Care Systems of Pennsylvania, Inc.* and *Pacificare of Oklahoma vs. Burrage* held that ERISA does not preempt claims that allege HMO liability for a doctor's negligence. Under a theory known as vicarious liability the physician acts not as an independent contractor but as an agent for the HMO. The HMO then becomes liable for its actions and policies such as the financial incentives it uses to coerce physicians to practice in a particular way. For the first time, instances where HMO strategies to save money collide with the patient's right to receive quality of care have come under the scrutiny of the law.

A recent case in Missouri illustrates this new trend. A surgeon with an unusually complicated case asked the primary care physician (gatekeeper) to call in another specialist. The HMO advised the primary care physician that the cost to refer to a specialist would be deducted from his withhold. The primary care physician decided to treat the patient himself. The patient suffered a grave complication and filed suit.

At the trial the plaintiff's attorney asked the primary care physician some very telling questions about financial incentives under which primary care physicians operate in a gatekeeper HMO.

Plaintiff's attorney: "Doctor, is it true that you make more money if you do not refer the patient to a specialist?"

Physician: "Yes."

Plaintiff's attorney: "And furthermore, doctor, is it true that you make less money if you do refer a patient to a specialist?"

Physicians: "Yes."

Plaintiff's attorney: "Doctor, you put your own financial interest ahead of the patient's welfare, didn't you?"

The jury returned a six figure judgment against the primary care physician. It is well established that juries are outraged when insurance companies or doctors deny care for financial reasons. This line of questioning can be used against any physician working in an HMO which employs capitation and withholds not matter how conscientious he or she is.

It is a sad commentary that the real villain, the HMO, which coerced and intimidated the doctor, was not held liable. Without the protection of ERISA this may no longer be the case. The HMO, under the yoke of state law might even have to face huge punitive damages.

There are far reaching implications for physicians who work under capitation and withholds. Courts are now addressing the problem of whether financial withholds constitute a breach of the physician's fiduciary duty to patients. If the courts find that they do, then juries in the future could find defendant doctors guilty not only of medical malpractice but breach of fiduciary responsibility and award judgments on both causes of action.

What will happen if U.S. courts follow the precedents set in the 3rd and 10th circuit courts and send malpractice cases against HMOs back to the state courts?

At the American Tort Reform Association (ATRA) meeting in St. Louis this past October, Mr. Philip R. Hinderberger, a representative of the professional liability insurers industry (the industry which will pay the bills if there is another malpractice crisis) said, "Suddenly the HMO industry and presumably the self-insured employers that employ similar cost control mechanisms will find themselves with hundreds if not thousands of state tort claims with the potential for ruinous verdicts like the $89 million awarded in the *Fox vs. Health Net*. The insurance industry will respond as it must by raising premiums... These added costs will quickly deplete the HMOs working capital until they can, in turn, pass the costs on to the heath care consumers and government programs like Medicare and Medicaid."

If such a scenario unfolds, managed care, at least capitation models which employ withholds, would offer no advantage over PPOs or traditional insurance in controlling health care costs. The liability risks in gatekeeper HMO models might be so great that they could shut down.

Mr. Hinderberger also noted that self insured employers might be sued and face ruinous verdicts.

Plaintiff's attorney: "Doctor, is it true that you make more money if you do not refer the patient to a specialist?"

Physician: "Yes."

Plaintiff's attorney: "And furthermore, doctor, is it true that you make less money if you do refer a patient to a specialist?"

Physician: "Yes."

Plaintiff's attorney: "Doctor, you put your own financial interest ahead of the patient's welfare, didn't you?"

The insurance companies, whether HMO, PPO or indemnity, act legally as third party administrators (TPAs). Under ERISA self insured employers as well as the insurance companies have escaped accountability.

When employees start suing their employers for medical malpractice or denial of benefits, the situation will become intolerable to the employer. Adding this factor to the potential huge liability costs which employers will face without the protection of ERISA will cause them to think twice before insuring the health care of their employees.

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"Suddenly the HMO industry and presumably the self-insured employers that employ similar cost control mechanisms will find themselves with hundreds if not thousands of state tort claims with the potential for ruinous verdicts like the $89 million awarded in the *Fox vs. Health Net*."

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If courts remove the protection of ERISA, the link between employment and insurance could be severed. There is increasing support among various segments of the population for this option. The AMA supports both employer mandates and individual insurance. Individually owned insurance is certainly more consistent with our democratic traditions which emphasize individual rights not corporate prerogatives. Insurance companies would, as in the Federal Employment Health Benefits Plan, compete for the business of the individual consumer not the employer. Medical savings accounts would become more popular. The focus of the free market would be the consumer, not the corporation. Medicine would cease being just another commodity to be factored into the final cost of the product or service of a particular company.

What will the strategy of managed care be now that it appears that their dubious practices will no longer be shielded by ERISA? Managed care hopes to weather the storm by taking the high road and support tort reform through enactment of the best malpractice statute in the country, California's Medical Injury Compensation Reform Act of 1975 (MICRA). The managed care industry has already joined the Health Care Liability Alliance, a lobbying coalition representing a broad spectrum of health care interests including the AMA. Managed care knows that the day of reckoning is at hand. Without the protection of a statute like MICRA, an onslaught of law suits could finish off managed care financially.

What strategy should physicians take? Physicians themselves have been powerless in trying to curb the evils of managed care. As always, first and foremost, we should be patient advocates. This means that we should support and assist the efforts of the civil justice system to remove the shield of ERISA from managed care organizations. Organized medicine should enter into a dialogue with the judiciary and the trial bar. As patient advocates we should point out the harmful effects of withholds and capitation on patient care.

The AMA already has an ongoing project to collect physician experience with managed care. Because of the medical profession's negative experience with our legal system it is understandable that many physicians might be reluctant to enter into a dialogue with the trial bar. Yet such a dialogue is not unprecedented. Tort reform was enacted in Missouri and other states by just such a coalition of judges, trial attorneys and physicians. In my opinion managed care is as important if not more important, an issue than tort reform. **MoMed**

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Improved Method for Deep Thoracoscopic Lung Nodule Excision

Todd L. Demmy, MD, David Nielson, MD, and Jack J. Curtis, MD

Minimally invasive excision of deep lung nodules can be difficult partly because endoscopic staplers do not open wide enough. We describe a method in which a standard atraumatic straight clamp compresses the lung to allow placement of the stapler without difficulty.

Lung nodules that are small and close to the viceral pleura are excised readily using video assisted thoracic surgery (VATS). If nodules arise deeper within the lungs, their excisions are hampered by difficulties bringing the necessary amounts of parenchymal tissue within the jaws of the endoscopic stapling devices. This is because the maximal separations between the stapler cartridges and the opened anvils are restricted by the designs of the instruments. Because of this limitation, lung tissue may be damaged in an attempt to force it into the stapler. Alternatively, the stapling device may be abandoned or used in conjunction with another technique like laser excision.[1] Other techniques may have higher rates of postoperative complications such as prolonged air leaks or bleeding.[2] We developed a technique to reduce lung manipulation and trauma when placing the endoscopic stapling device, simplify stapling, and expedite VATS excision of deep lesions.

Enhanced Lung Nodule Excision Technique

After induction of general anesthesia, single lung ventilation is performed and the lung is collapsed on the operative side. It is the authors' preference to use a left dual lumen endobronchial tube for operations on the right lung and a left bronchus blocker for operations on the left lung. The former is also preferred when one anticipates delayed collapse of the lung from obstructive pulmonary disease because the nonventilated side can be opened to atmospheric pressure rather than relying on absorptive atelectasis. Sometimes the lung nodule is localized best before the operation by CT guided percutaneous hook wire or dye injection.[3] After creation of the pneumothorax, a video telescopic camera is inserted through a port at the mid-axillary line in the eighth intercostal space. This allows careful visual control during creation of thoracostomy sites near the anterior and posterior axillary lines through the fifth or sixth intercostal spaces. Then a standard or endoscopic atraumatic grasping instrument (e.g. Babcock clamp) is used to control the lung near the suspicious nodule. The target parenchyma can be moved near one of the other thoracostomy sites for palpation if the nodule is not visible and the lung is elastic enough. The direction of stapler application is then selected and the thoracostomy site that would best facilitate this is used. Through this site, a straight atraumatic vascular or intestinal clamp (e.g. Dennis clamp) is placed. The hinge of the clamp is frequently near or within the chest wall. This clamp is applied to the lung so that the opened endoscopic stapler can slide between the clamp and the nodule. The stapling device is brought through the same entry hole, opened and applied across the compressed tissue effortlessly. The atraumatic clamp is then opened and withdrawn leaving the lung tissue within the jaws of the stapling device. This stapler jaws can be moved farther away from the lesion if a greater margin is needed. The instrument is then fired and the steps above can be repeated until the lesion is totally excised. A specimen is removed by placing it within a latex glove or a plastic specimen extraction sack designed to prevent contamination of the chest wall wound by tumor or infectious material. A diagram and intraoperative photograph depicting placement of the clamp and stapler are shown in Fig 1.

Comments

In our study of an early series of video assisted thoracic operations, we found that complication rates were reduced by advances in VATS technology and also the surgeons' increasing experience with the technology.[4] The use of this technique has prevented the conversion of thoracoscopic operations to thoracotomies in two patients and has decreased the time required to complete the stapling procedure in four others. There have been no parenchymal lacerations or other injuries probably because the clamp is simple to apply and the force of closure is transmitted to the surgeon in a manner that is easy to gauge.

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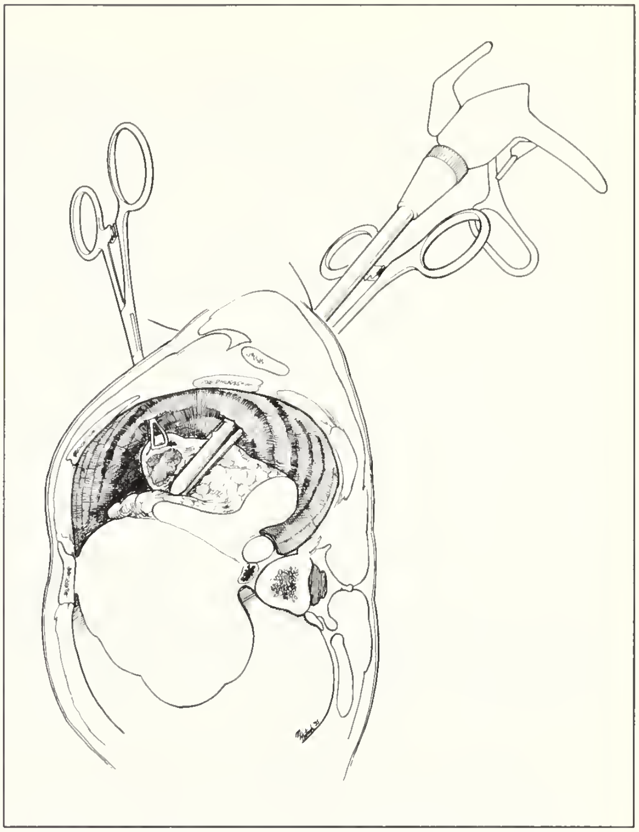

Figure 1a. Transverse section diagram of mid-left thorax showing typical placement of instruments for deep lung nodule excision.

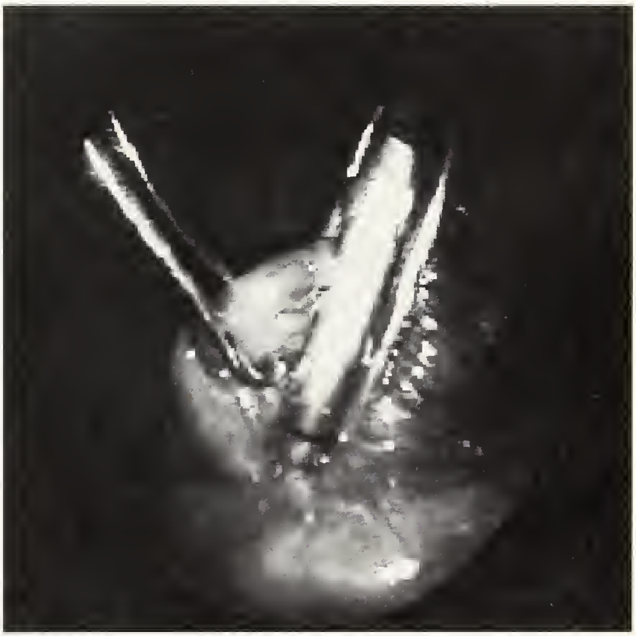

Figure 1b. Intraoperative photo corresponding to diagram.

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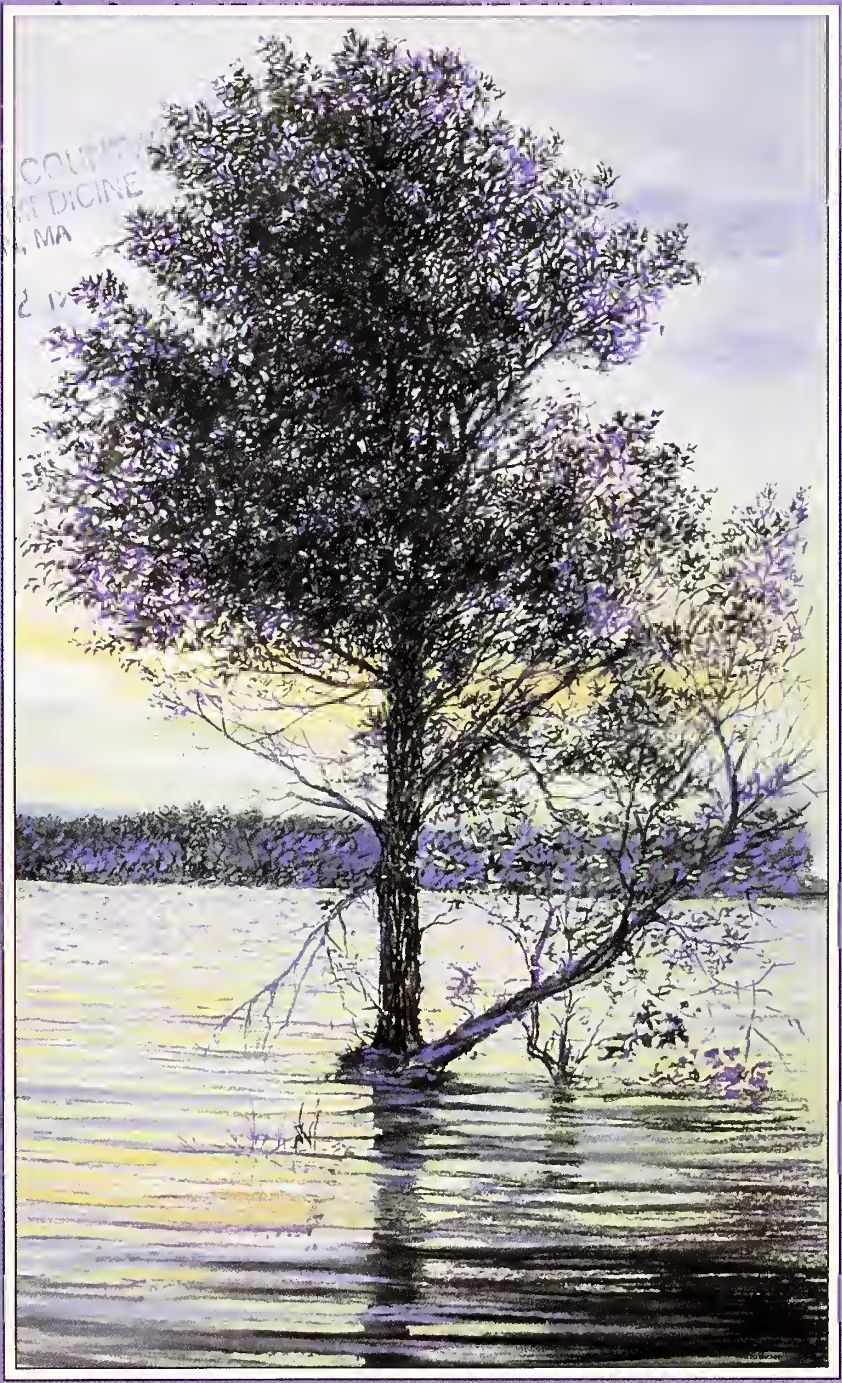

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, [ISSN 0026-6620] is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. **Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept., P.O. Box 1028, Jefferson City, MO 65102.** The subscription price per year for non-members is $60.00. Annual subscription for members is included in the annual membership dues. Single copies are $8.00 and the per copy cost of the annual August Directory is $40.00. Copyright 1996 by the Missouri State Medical Association. The opinions expressed by the authors are not necessarily those of the Missouri State Medical Association nor should publication be considered an endorsement by the MSMA. Printed by the Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

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On the Cover: "Norfolk Lake" a watercolor & pastel by Terry Martin. Mr. Martin is a professional artist. He is currently an instructor of art for William Woods College in Fulton, Missouri.

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How are we doing?

J. Regan Thomas, MD, Editor

As mayor of New York, Ed Koch was fond of asking, "How am I doing?" as he walked the streets of the Big Apple. We decided to pose a similar question on behalf of *Missouri Medicine*. With the help and support of our contributors, the ninety-second volume of the Journal has been presented and represents the tradition as well as tangible image of the Missouri State Medical Association. Over 20 scientific articles and 12 "Perspectives" articles were published. In addition to the "Editor's Desk," a number of regular departments were provided monthly including the President's Page, the Public Health Reports, Practice Management, Medical Legal Issue of the Month, and the monthly medical specialty quiz. We are proud to continue to have contributed to this long history of our state journal. It seems appropriate as we begin to approach the 100 volume mark, to get feedback as to how well we are doing our job.

A survey was instituted and initially provided to our Council. The Council provided a representative "focus group" and an excellent cross section of our membership. This group has an average MSMA membership range of over 15 years (with nearly half having over 20 years membership.) Most read the Journal on a regular monthly basis. The largest group reports reading habits described as scanning each issue with a certain section read primarily each month. Most described the information as "very valuable" to "some value." Not surprisingly, most respondents reported "always" reading their specialty journals. *AMNews* also ranks highly with many.

The popularity and usefulness of the Journal for our membership is being examined. There are significant budget issues being addressed by MSMA as in many of today's organizations. One area of consideration is the possibility of changing the traditional monthly schedule to a quarterly publication. Some may even wish to drop the publication altogether as a cost savings. Time will tell, of course, but the real measure of our importance and usefulness is your opinion. We would like to know what you think. If you have ideas for change or thoughts about the value of a monthly state journal, let us know by writing us. We are anxious to hear your answer to "How are we doing?" MoMed

A readership survey is being sent randomly to 1,400 MSMA members requesting their opinion about the format, content, and frequency of *Missouri Medicine*. Any member wanting to make comments regarding the Journal may call, fax or write Angela Allen, managing editor at MSMA, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102; Tel (573)636-5151; Fax (573)636-8552.

Missouri Osteoporosis Foundation

1996 CONFERENCE ON OSTEOPOROSIS

cosponsored with the

St. Louis Metropolitan Medical Society

Saturday, May 4, 1996

7:30 a.m. Continental Breakfast • 8 - 1:30 Program

Ritz-Carlton St. Louis
100 Carondelet Plaza

Topics on Osteoporosis Standard of Care, 1996

- Epidemiology of Osteoporosis
  L. Joseph Melton III, MD, Mayo Clinic
- Use of Bone Mass Measurement and Biomarkers in the Diagnosis and Treatment of Osteoporosis
  Roberto Pacifici, MD, Washington University School of Medicine
- Non-Estrogen Therapies for Osteoporosis
  Louis V. Avioli, MD, Washington University School of Medicine
- Estrogen Therapy After Menopause
  Robert Lindsay, MD, MB Ch. B, PhD, FRCP
  Helen Hayes Hospital, Clinical Research Center, NY
- Question and Answer During Lunch

The objective of the meeting will be to acquaint practicing physicians with new developments in the field of osteoporosis, including a clearer concept of who should be considered for treatment; the FDA approved drugs for treatment, including two new, recently approved; and new diagnostic and therapeutic monitoring techniques.

Conference Director & Moderator: Barbara B. Sterkel, MD

The St. Louis Society for Medical and Scientific Education is accredited by the Missouri State Medical Association to sponsor continuing medical education for physicians. The SLSMSE designates this continuing medical education activity as meeting the criteria for 5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

Reservation fee of $50 must be received by April 27. Please make check payable to: Missouri Osteoporosis Foundation. Mail to: St. Louis Metropolitan Medical Society, 3839 Lindell Boulevard, St. Louis, Missouri 63108.

Pride of Ownership

Frederick Hahn, MD, MSMA President

I was recently sitting at a table next to a good friend as we enjoyed the annual hospital fund-raising gala. My friend is the administrator of a small community hospital which in the last few years has purchased the practices of the majority of the primary care physicians who served his institution.

As we looked around the auditorium, he noted that not one of the physicians who were now employees of the hospital were present. He was truly disappointed at the 100% absence and seemed puzzled as to why this was true. Indeed it was assumed that the physicians' incomes had been uniformly and significantly improved with the buyout arrangements.

This mini-scenario lingered in my mind since that evening and I have had cause to reflect on it a number of times. It caused me to reflect a bit further back to a journey which my wife Marge and I took from Austria into what was then "red" Hungary before the Iron Curtain came down.

We were motoring from Vienna eastward across lush fields of wheat which stood chest high. When we reached the border of Hungary we were halted by soldiers with weapons who demanded that every case which we carried be laid open on the ground for inspection.

This was not at all unexpected. However, when we got back into the bus and motored on toward Budapest, my farm background alerted my eyes to something much more contrasting. As far as one could see, fields of wheat spread toward and disappeared at the horizon. No fences or division of property was apparent. At this juncture, the wheat was sparse, spindly and no taller then one's knees.

Scattered along the way there were tiny villages of very modest homes occupied by farmers. Around the homes were fences with no more than 10 to 15 feet of yard space between the home and the fence. This apparently represented the private domain of each occupant. In these tiny spaces were the most luxurious gardens one would ever hope to see. The plants were tall, lush, and obviously well cared for.

These open fields behind the Iron Curtain represented the apathy of the communistic state. The tiny gardens in contrast reflected a beautiful example of the pride of ownership.

The government which we have endorsed has championed the concept that managed care is the answer to the mounting and seemingly out of control cost of health care. As I reflect on that gala evening, lingering visual images of the fields in Hungary join with images of health care Wal-Marts gobbling up each other in a frenzied effort to become the remaining dinosaur in the "Jurassic Park" of medicine; I wonder, if "bigger is better," then how big?

In reading *The Road Ahead* by Bill Gates, I felt that he too is struggling with a "Catch 22." On the one hand he mentions the merits of small businesses and their prospects of survival due to the availability of the same information highway which has allowed large businesses to succeed. In the same breath, he extols his personal satisfaction in maintaining Microsoft's almost unchallenged control of the computer software world.

It is the small businesses of America that have been the back bone of our economy throughout our country's history. As I leave office next month and with this issue of *Missouri Medicine*, I continue my affirmation in the belief in the right of each of my peers to play a major part in his or her professional destiny. I also affirm my belief in truth, honesty, justice, hard work, and the ever sacred patient-physician relationship. **MoMed**

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Radiology Quiz #2

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

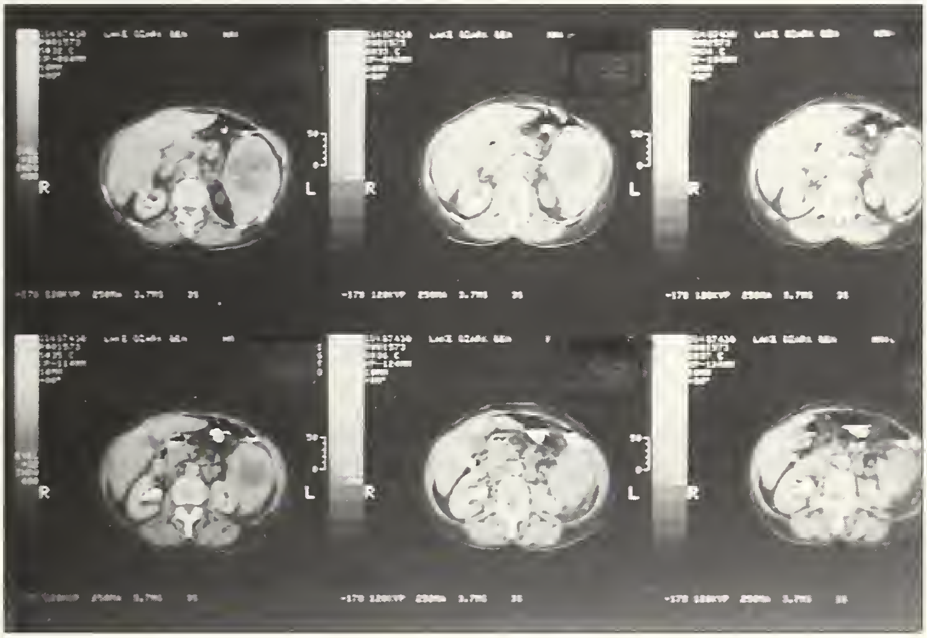


Figure 1

A 75-year-old woman was admitted to the hospital with a history of a 20 lb. weight loss. A C.T. scan of the abdomen was performed, with contrast enhanced slices of the upper abdomen (Fig 1).

What is the likely diagnosis?

a. Liver Metastses
b. Lymphoma
c. Pancreatic carcinoma
d. Bowel obstruction

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

ANSWER: b. Lymphoma

C.T. slices through the upper abdomen show a markedly enlarged spleen containing a large low attenuation mass (arrows) centrally. There are also several enlarged periaortic lymph nodes near the left kidney (arrowheads). The presence of a mass in an enlarged spleen with enlarged lymph nodes would be most suggestive of a lymphoma or metastatic carcinoma. Laparotomy was performed with splenectomy and periaortic lymph node biopsy. Histologic diagnosis was malignant lymphoma, immunoblastic type (option B is the correct response).

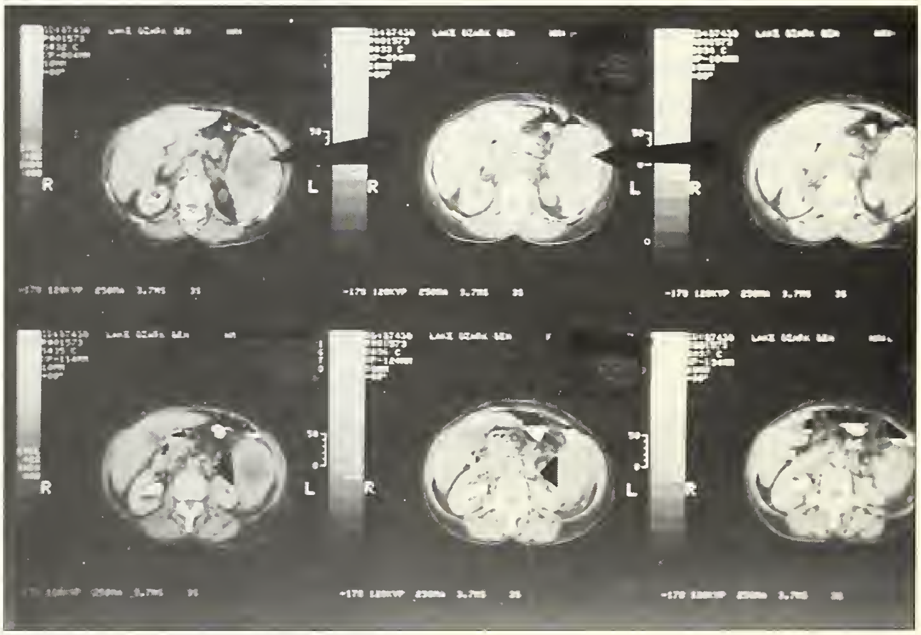
Imaging evaluation of the spleen can be performed by multiple modalities, including ultrasonography, nuclear scintigraphy, computerized tomography and magnetic resonance imaging. Of these, C.T. scanning is probably the most widely used for detailed anatomic evaluation of the spleen. MRI is somewhat limited by respiratory motion in the upper abdomen. Nuclear scintigraphy is a screening tool that is limited by spatial resolution which is less than the other modalities. Ultrasonography is an inexpensive way to evaluate the upper abdomen, but is limited by operator dependence and obscuration of organs by bowel gas in some patients.

Option A, liver metastses is unlikely since no liver masses or enlargement are seen. Option C, pancreatic carcinoma is unlikely since the pancreas is well seen with no evidence of mass or enlargement.

Option D, bowel obstruction is unlikely since no dilated bowel loops are seen.

Reference

1. Freeman JL et al. C.T. of congenital and acquired abnormalities of the spleen. *Radiographics* 1993;13:597.
2. Robushka LS et al. Imaging of the spleen: C.T. with supplemental M.R. examination. *Radiographics* 1994;14:307.



Repeat Figure 1

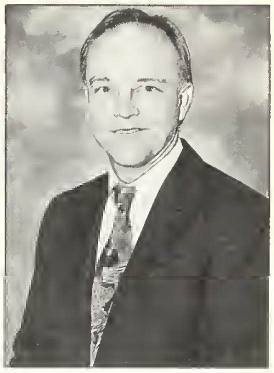
Left to right: Kelby Krabbenhoft, President/CEO of Freeman Hospitals & Health System in Joplin, Former British Prime Minister Lady Margaret Thatcher, Hugh Stephenson Jr., MD, and Gayle McAllister, Chair of the Freeman Foundation.

Hugh E. Stephenson Jr., MD, John Growden Distinguished Professor of Surgery Emeritus, at the University of Missouri-Columbia School of Medicine, was named the winner of the Freeman Foundation Quality in Medicine Award in a ceremony held in Joplin, Missouri. Former Prime Minister Lady Margaret Thatcher presented the award to Dr. Stephenson as well as giving an address to patrons, benefactors and invited guests.

The award was established in 1991 to distinguish a degree of excellence put forth by an individual, group, organization or corporation that has demonstrated actions that have resulted in the advancement of the quality of medicine.

Dr. Stephenson is a longtime faculty member at the University of Missouri-Columbia. His first textbook, *Cardiac Arrest and Resuscitation*, has become a classic. Cardiopulmonary resuscitation, a mainstay in emergency medicine and surgery today, evolved largely from his initial work with cardiopulmonary arrest in the 1950s.

The award was made possible by Blue Cross/Blue Shield of Missouri; Investors Financial Inc. of Joplin; and UMB Bank, Southwest, Joplin-Carthage.



J. Stuart Munro, MD

J. Stuart Munro, MD, has been appointed interim dean of the University of Missouri-Kansas City. A search and screening committee is being established to fill the position of executive director and dean, a post vacated by James J. Mongan, MD. Dr. Mongan will assume the position of president and chief operating officer of Massachusetts General Hospital in Boston late this month.

Martin B. Wax, MD, associate professor of ophthalmology and visual sciences at Washington University School of Medicine, received a three-year grant from the National Eye Institute for a research project titled, “Vaculoar H+-Atpase in the Ciliary Epithelium.”

AMA PHYSICIAN'S RECOGNITION AWARDS

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs:

Charles H. Andrus, *St. Louis*
Frederick D. Bauschard, *St. Louis*
James K. Fisher, *Kansas City*
Charles F. Garvin, *Chesterfield*
Terry E. Hall, *Bethany*
Thomas J. Hancock, *Jefferson City*
Campbell P. Howard, *Kansas City*
Akira Iwane, *Chesterfield*
Charles R. Kelly, *Kansas City*
Stanley W. Kim, *St. Louis*
Jack M. Mantell, *Springfield*
Thomas D. Margulies, *St. Louis*
George A. Richardson, *Union*
Catherine L. Schane, *Springfield*
James A. Schell, *Columbia*
Thomas L. Schmidt, *Kansas City*
Thomas C. Sparkman, *Cape Girardeau*
David L. Straub, *Joplin*
Donald A. Withrow, *St. Louis*

New Members

Boone

James C. Robinson, MD - OPH
1 Hospital Dr. Dept., OPH UMC
Columbia, MO 65212
Univ of Wisconsin; 1985

Timothy B. Watson, MD - AN
800 Hospital Dr., Anesthesia Services
Harry S. Truman VA Hospital
Columbia, MO 65201
Indiana University; 1980

Buchanan

Robert C. Johnson, MD - RO
901 Robidoux St., St. Joseph, MO 64501
University of Kansas; 1989

Clay-Platte

Dianna L. Cargill, MD - OBG
28 Westwoods Dr., Northland OBGYN
Liberty, MO 64068
University of Oklahoma; 1991

Susan H. Carney, MD - OPH
9836 Ash Dr., Overland Park KS 66207
University of Missouri, KC; 1988

Cole

Daniel K. Boatright, DO - AN
1021 C-2 Southwest Blvd.
Jefferson City, MO 65109
Kirksville Coll of Osteo Med; 1986

Dallas-Hickory-Polk-Dade

Fernando L. Cavero, MD - IM
1125 N. Butterfield, Bolivar, MO 65613
University of Illinois; 1988

Grand River

Lazaro U. Rabang, MD - IM
2525 Miller St., Bethany, MO 64424
Far Eastern University; 1989

Jefferson

Mary Eleanor Beal, MD - IM
P. O. Box 1285, Festus, MO 63028
University of Minnesota; 1981

Mark D. Hingst, MD - FP
514 Jungerman, St. Peter, MO 63376
St. Louis University; 1984

Metro Med of Kansas City

Dirk H. Alander, MD - ORS
4320 Wornall Rd., Ste. 610
Kansas City, MO 64111
Univ of Illinois, Chicago, IL; 1984

William C. Cirocco, MD - CRS
8901 W. 74th St., Ste. 149
Shawnee Mission, KS 66204
Wayne State University, MI; 1985

Kathryn M. Eschmann, DO - P
6400 Prospect, Ste. 540
Kansas City, MO 64132
Kirksville Col of Osto Med; 1988

Brad L. Freilich, MD - GE
6650 Troost, Ste. 405
Kansas City, MO 64131
University of Missouri, KC; 1988

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1010 Carondelet #10G
Kansas City, MO 64114
University of Kansas; 1990

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Kansas City, MO 64108
University of Michigan; 1982

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University of Kansas; 1988

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MSMA Only

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Washington University; 1984

North Central

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902 E. LaHarpe, Kirksville, MO 63501
University of Virginia; 1988

Perry-Ste. Genevieve

Melquiadito M. Allego, MD - NM
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Perryville, MO 63775
Southwestern Univ., Philippines; 1968

Mark W. Bonneville, MD - FP
434 N. West St., Perry Co Mem Hosp
Perryville, MO 63774
St. Louis University; 1984

Mazen M. Kadri, MD - PUD
Box 468, Ste. Genevieve Hospital
Ste. Genevieve, MO 63670
Damascus University, Syria; 1987

Muhammad A. Riaz, MD - R
P. O. Box 468, Memorial Hospital
Ste. Genevieve, MO 63670
King Edward Med Col Pakistan; 1992

*MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to **Missouri Medicine**, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

What your patients should know about MEDIGAP (Medicare Supplement Insurance)

Within the first six months of becoming eligible for Medicare, individuals are in an "open enrollment" period for Medicare supplementary insurance, also known as Medigap.

This is not a one size fits all product. Consumers should consider many points before selecting the proper policy: Which benefits are most needed? What is the insurance company's rating? What is the premium? In the Medigap market, the menu of benefits is varied **(See back side of this form)**.

It is wise to receive multiple quotes. Ratings of insurance companies are reflective of the company's financial statements. Company's with an A+ rating (very good) may have lower only slightly higher premiums than a company with a C rating, but if the C rated company goes out of business, then the buyer has lost the opportunity to get in during the open enrollment period.

Consumer Advice:

- Never buy insurance you do not understand.
- Never change policies without a good reason.
- Make sure your Medicare supplement insurance covers you for your entire life.
- Know your agent.
- Keep good records.

The Qualified Medicare Beneficiaries (QMB) portion of Medicaid covers persons who have both incomes and assets below certain limits. If you fall below these income levels, you do not need Medicare supplement insurance. Contact your Medicare office for further details. It is estimated that less than half those eligible for QMB apply for it.

Medicaid also covers long-term care expenses for people below certain income levels. Medicare and Medicare supplement insurance do not cover long-term care. Ask your insurance agent for details about the Long-Term Care Insurance.

Limitations of MEDIGAP

Your Medicare supplement insurance does not pay for any amounts paid by Medicare. Both Medicare and your Medicare supplement insurance exclude:

- Acupuncture treatment;
- Care in a nursing home, or in a skilled nursing facility not certified by Medicare
- Care provided by family members, unpaid volunteers, providers who are not care providers
- Cosmetic surgery, unless due to injury, trauma, infection or disease;
- Custodial care;
- Dental care and dentures;
- Eye exams and eyeglasses;
- Hearing exams and hearing aids;
- Private duty nursing;
- Services not reasonable or medically necessary;
- Treatment due to war or act of war;
- Treatment paid for or furnished by the government or Workers Compensation.

A pre-existing condition is a sickness or injury for which you were treated within three months before you enrolled in the coverage. Benefits for pre-existing conditions are not paid until: **Three months pass after you enroll under the Medicare supplement coverage.**

Enrolling within the six-month guaranteed issue period does not automatically satisfy the pre-existing condition requirement. However, continuous coverage under prior Medicare supplement insurance counts toward your three-month requirement.

NOTE: Before buying MEDIGAP Insurance, consider how Medicare HMO coverage would affect your plan selection.

The Missouri Department of Insurance publishes an annual buyer's guide. For a copy write: Missouri Dept. of Insurance; PO Box 690; Jefferson City, MO 65102-0690 or call the Consumer Hotline: 1-800-726-7390.

This information has been made available to members of the Missouri State Medical Association for distribution to their patients.

PLAN OPTIONS

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At Home Recovery		At Home Recovery	At Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

All plans include the basic benefits:

- Hospitalization: Part A coinsurance ($179 per day from 61st to 90th day and $358 from 91st to 150th day) plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
- Blood: First three pints of blood each year.

Plans B through J contain added benefits, which may include:

- Skilled nursing facility care coinsurance ($89.50 per day for days 21 through 100 per benefit period in 1995).
  (Benefit period begins on first day of inpatient service and ends after you have been out of hospital or skilled nursing facility for 60 days in a row.)
- Part A inpatient hospital deductible ($716 per benefit period in 1995).
- Part B deductible ($100 per calendar year in 1995).
- Part B excess (either 80% or 100% of the difference between Medicare's approved amount for Part B services and actual charges).
- Medically necessary emergency care in a foreign country of 80%, up to a $50,000 lifetime maximum after a $250 calendar year deductible.
- At-home recovery benefits up to $1,600 per year for short term, at-home assistance with activities of daily living for recovery from illness, injury or surgery.
- Prescription drug costs at 50% coverage up to a maximum annual benefit of $1,250(H&I) - $3,000(J) after a policyholder meets a $250 per year deductible.
- Preventive medical care up to $120 per year for physical exams, preventive measures, screenings and tests.

The plan options are spelled out in the " Guide to Health Insurance for People with Medicare".

This information has been made available to the members of the Missouri State Medical Association for distribution to their patients.

Claims for Lost Chance of Survival in Missouri

Joseph C. Blanton Jr.

The liability of health care providers has continuously expanded during the past several decades. The only retrenchment in this expansion of liability in Missouri occurred in 1986, when the Missouri Legislature enacted the Medical Malpractice reform statutes in Chapter 538, R.S. Mo. Otherwise, in Missouri, as in virtually every other state, plaintiffs' counsel have aggressively sought to expand the boundaries of liability in the health care field. The relatively new tort of "lost chance of recovery" is part of this expansionary trend.

Ordinarily, to establish a medical malpractice claim in Missouri, a claimant must prove three elements:

1. An act or omission of defendant failed to meet the requisite standard of care;
2. The act or omission was negligent; and
3. There was a causal connection between the act or omission and the injury sustained.

A claimant in a medical malpractice action must prove each of these elements through expert testimony. A claim for lost chance of survival provides a claimant with a way around problems of proof relating to the third element, causation.

To understand the significance of lost chance of survival claims, it is useful to review principles which ordinarily apply to causation issues in medical negligence cases. The best explanation of the causation element is set forth in *Callahan v Cardinal Glennon Hospital*, 863 S. W. 2d 852 (Mo. en banc 1993). There, the Missouri Supreme Court en banc held that a plaintiff's tort claim must pass two tests of causation: 1) the omission must be the cause in fact of injury (the "but for" test); and, 2) the omission must be the proximate cause of the injury. The "but for" test is the starting point. It is satisfied only if the injury would not have occurred "but for" the Defendants' negligence. If the alleged injury would have resulted even in the absence of the alleged wrong, the Plaintiffs' claim is legally inadequate. As the Supreme Court noted in *Callahan*:

> "But for" is an absolute minimum for causation because it is merely causation in fact. Any attempt to find liability absent actual causation is an attempt to connect the defendant with an injury or event that the defendant had nothing to do with. Mere logic and common sense dictate that there be some causal relationship between the defendant's conduct and the injury or event for which the damages are sought."

Under this "but for" test, which is the first hurdle a claimant must jump to prove the causation element of his or her claim, a health care provider is responsible for an adverse result only if the result would not have occurred absent the alleged malpractice. For example, in a case involving a delay in the diagnosis of cancer, the key inquiry is whether that delay cased any adverse outcome which would not have occurred anyway. If the patient would have lost a limb or died from the disease in any event, and the cancer would have required the same treatment, the claim obviously cannot satisfy the "but for" requirement.

The "but for" requirement, then, creates a class of alleged claims wherein the health care provider may have done something wrong, but for which there has traditionally been no recog-

Continued on page 110

Continued from page 109

nizable cause of action because the damage would have occurred in any event. It is in this situation where claimants have brought actions for lost chance of recovery. This type of legal action provides a recovery for a patient who more likely than not was destined to die or become permanently impaired from an underlying medical process or disease, but who suffered a decrease in the likelihood of recovery as a result of the malpractice.

The leading case in this area is *Wollen v DePaul Health Center*, 828. S. W. 2d 681 (Mo. en banc 1992). There, a widow of a deceased cancer patient brought a wrongful death action against the health care providers who failed to diagnose her husband's cancer. The Defendants in the case filed Motions to Dismiss, claiming that the Petition failed to allege that the decedent would not have died if the Defendants had not committed malpractice, i.e. the suit contained no allegation that the negligence of the providers caused her husband's death. The Circuit Court sustained the Motion to Dismiss. On appeal, the Missouri Supreme Court noted that there are three types of medical situations which occur in medical negligence litigation: 1) diseases that are usually cured unless there is some malpractice; 2) diseases which are invariably fatal in any event; and 3) diseases or illnesses which have treatments which both work and fail in a large number of instances. As to this third category, the Missouri Supreme Court in *Wollen* noted that "it is impossible for a medical expert to state with 'reasonable medical certainty' the effect of the failure to diagnose on a specific patient, other than the fact that the failure to diagnose eliminated whatever chance the patient would have had."

The Supreme Court in *Wollen* agreed with the medical providers there that the Plaintiff could not prevail on her wrongful death case because Plaintiff could not honestly allege nor prove that her husband would not have died if the cancer had been detected earlier. However, the Supreme Court accepted the suggestion by the Plaintiff that it should consider whether to recognize an alternative theory of recovery, i.e. a claim for lost chance of recovery based on the Restatement (Second) of Torts Sec. 323. The Supreme Court then considered both whether it should adopt this common law cause of action and, if so, whether the Plaintiff had pleaded facts which would constitute a cognizable claim.

On this first point, whether to adopt the cause of action for Missouri, the Supreme Court noted that a black and white view of causation is often not very realistic. The Court noted that "medical science has given patients real chances to recover, sometimes only a small chance, but still a chance, in circumstances that used to be hopeless." To provide that a patient had no cause of action when he was deprived of this chance would be unfair. As the Court noted:

> A patient with cancer, like Mr. Wollen, would pay to have a choice between three unmarked doors - behind two of which were death, with life the third option. A physician who deprived a patient of this opportunity, even though only a one-third chance, would have caused her real harm. In light of this reality, the patient does suffer a harm when the doctor fails to diagnose or adequately treat a serious injury or disease. The harm suffered is not, however, the loss of life or limb. The harm is the loss of the chance of recovery."

Based upon this analysis, the Supreme Court decided to relax the "but for" causation requirement and to recognize a cause of action for lost chance of survival in situations where the alleged wrong by the health care provider caused a decrease in the likelihood of recovery, but an expert could not honestly testify that the outcome would not have been the same. The Supreme Court further found that the Petition in *Wollen*, while failing to state a wrongful death action, could conceivably state a claim for lost chance of survival under R.S. Mo. Sec. 537.020, the survival of actions statute. The Court reversed the lower court's decision and sent the case back to the Circuit Court with the direction that the Plaintiff be allowed to amend the Petition to attempt to assert a claim for "lost chance of survival."

The significance of this decision cannot be overemphasized. In certain situations the "but for" requirement set forth in *Callahan* does not apply. Claims of persons with diseases or underlying injuries which are often fatal, and who cannot satisfy the "but for" requirement, are now viable if they can demonstrate a decrease in their chance of recovery. They need no longer prove that the alleged malpractice was the cause of their injury or death. They can prevail on a lost chance of recovery case if they can show that the malpractice decreased their chances of recovery, even if the chances of recovery were not very good.

What does this decision mean in practical terms? First, a party claiming that he or she, or his or her decedent suffered a lost chance of recovery must bring an ordinary medical malpractice action, not a wrongful death suit. This distinction will have significance in terms of who can bring the action, when it must be brought, and what can be recovered. The proper plaintiff will be either the injured person or, if he or she dies, his or her personal representative pursuant to R.S.Mo. Sec. 537.020.1. Since a claim for lost chance of survival is not technically a wrongful death suit, the two (2) year statute of limitations applicable to medical negligence actions, R.S. Mo. Sec. 537.105, will probably apply, rather than the three (3) year statute applicable to wrongful death actions. Further, this two (2) year period begins to run not from the death of the patient, as with a wrongful death case, but when the wrong occurs.

What damages are recoverable? The Supreme Court in *Wollen* answered this question in general terms. The Court noted that the damages in a lost chance of recovery case "can only be expressed by multiplying the value of a lost life or limb by the chance of recovery lost." For example, if the jury believes that the value of the remaining part of a descedent's life was $500,000 and further believes that the negligence of health care providers caused a decrease in his or her chance of survival by 50%, the appropriate award would be $250,000.

Of note, although the Supreme Court in *Wollen* did not draw any lines, footnote 3 to the Court's opinion suggests that a de minimis decrease in a patient's chance of survival will not be compensable, stating:

> This action will be limited to those cases in which the chance of recovery lost was sizeable enough to be material, which must be so found by the jury. In the event statistics constitute relevant evidence, the lost chance must be statistically significant within statistical standards.

There has been only one case of consequence decided by a Missouri appellate court since the Missouri Supreme Court's adoption in *Wollen* of the lost chance of survival cause of action. This case is instructive, however. In *Morten v Mutchnick*, 904 S. W. 2d 14 (Mo. App. 1995), the Missouri Court of Appeals held that the parents of an AIDS patient had no cause of action against health care providers who failed to diagnose his illness on a timely basis. The Court of Appeals reasoned that AIDS is invariably fatal at the present time and, therefore, the situation there fit within the second category of circumstances identified in *Wollen*, those involving illnesses which are almost always fatal. While the Court conceded that the Plaintiffs in *Morton* might be able to argue that their son's life was shortened by the health care providers' negligence, the Court refused to extend the holding in *Wollen* to cover that situation.

By relaxing the "but for" causation requirement in certain circumstances, claims for lost chance of recovery provide claimants in medical malpractice actions with remedies which would ordinarily not be available. Any statistically significant loss of a chance of recovery may result in litigation. Health care providers can now expect suits arising out of treatment of diseases which are often fatal, as long as they are not always fatal. Any defense based upon a contention that the patient would have probably died anyway will no longer suffice. MoMed

Joseph C. Blanton, Jr. is a partner in the Sikeston, Missouri law firm of Blanton, Rice, Sidwell and Ottinger. He specializes in medical malpractice and products liability defense as well as litigation of all types in Federal Courts. His father and two brothers are physicians.

The changing face of Medicare peer review: Collaborative project success stories

John Sotham, MPCRF Education Coordinator

The latest clinical consensus may help a physician to prescribe a better treatment, but what if there are breakdowns in the laboratory, radiology, or in the hundreds of other processes that go into delivering hospital care?

The key is that processes don't exist in a vacuum—we must examine the big picture, not just the immediate clinical treatment. The Missouri Patient Care Review Foundation (MPCRF), the state Medicare Quality Improvement and Peer Review Organization, (QIO/PRO) focuses on collaborative projects that help improve the continuum of care, and are ultimately focused on processes themselves, rather than on strictly examining the outcomes.

MPCRF's Health Care Quality Improvement Program (HCQIP) staff analyze large segments of Medicare claims data and identify areas where clinical processes could be improved. Such analysis often requires the retrieval of additional clinical information directly from medical records. HCQIP staff then engage hospitals and physicians in collaborative projects that focus on specific clinical issues. After baseline analysis, MPCRF works with each participating facility to develop an individualized action plan that maps out how improvements will be made. Measurements are then taken to determine the plan's effectiveness.

> "I think the key to shortening LOS for a given diagnosis is to have key physicians involved who are the best qualified to review the literature and make some rational recommendations."
>
> ***Mark Breite, MD, pulmonologist who helped guide implementation of the CAP Project at Jefferson Memorial Hospital (JMH) in Crystal City***

Both clinician buy-in and facility-wide coordination are important ingredients of a successful HCQIP collaborative effort, and both aspects were essential to one of the earliest HCQIP success stories, the Community Acquired Pneumonia (CAP) cooperative project. The HCQIP team convened a study group that examined clinical recommendations about pneumonia treatment made by the American Thoracic Society, which calls for basing initial patient management on both the severity of illness and the rapid initiation of the appropriate antibiotic treatment. The project focused on bacterial pneumonia only (ICD-9-CM codes 481-483.8, 482.9, 485 and 486). Depending on the facility, mortality and length of stay (LOS) are monitored separately or in conjunction with each other.

"I think the key to shortening LOS for a given diagnosis is to have key physicians involved who are the best qualified to review the literature and make some rational recommendations," says pulmonologist Mark Breite, MD, who helped guide implementation of the CAP Project at Jefferson Memorial Hospital (JMH) in Crystal City. "There were several publications that were calling for identifying high-risk patients, as well as the low-risk patients that you could send home or to another setting with a good margin of safety and not compromise care."

Like the pneumonia project, all HCQIP projects are based on sound clinical consensus derived from a qualified study group. In this way, MPCRF provides a way to communicate the latest research findings to Missouri providers. Chris Johansen, RN, JMH's

Director of Utilization Management and Social Services, had confidence in the soundness of the guidelines as she introduced the project to JMH medical staff. "Everybody, from the physicians to the nurses to the therapists, has a set way they think is the best way to do something," she says. "You have to challenge that and look at the latest information. That's why the report from the Thoracic Society was so great. It was hard to argue with its authority to recommend how to take care of a pulmonary patient."

While working on the Influenza Immunization Cooperative Project, key personnel at St. John's Regional Health Center in Springfield had to gain medical staff support even in the face of sometimes conflicting clinical priorities. The project was focused on the use of "windows of opportunity" such as hospital admission for assessing a patient's influenza and pneumonia immunization status. Representatives from a variety of disciplines were briefed on the project's goals, so that physicians could identify any patient populations that were contraindicated to participate.

"We learned quite a bit from the project, including how to save time and automate the process, and we learned about nurse-driven protocols and about physicians' acceptance of them. Everyone agrees that the project resulted in more immunizations and allowed a springboard for discussion," says James T. Rogers, MD, St. John's Utilization Management Medical Director and an MPCRF Board Member. "We went from no patients documented for immunization to more than 650, and we've got about as many vaccinated. The project highlighted the issue and allowed us to push pretty hard for the immunization of patients coming in for treatment."

> "Everybody, from the physicians to the nurses to the therapists, has a set way they think is the best way to do something. You have to challenge that and look at the latest information. That's why the report from the Thoracic Society was so great. It was hard to argue with its authority to recommend how to take care of a pulmonary patient." *Chris Johansen, RN, JMH's Director of Utilization Management and Social Services*

In addition to securing clinician buy-in and fostering education, facilities must examine their internal processes as well, says Gary Fortune, DO, MPH, MPCRF Principal Clinical Coordinator. "We found with the pneumonia project that many physicians quickly order an antibiotic when their patients present to the hospital," he says. "What we often find is that the processes that are used to implement the orders is where breakdowns occur. This changes the focus from specifically looking at the physician's role to looking at the overall processes inherent in the facility itself," Dr. Fortune says.

When HCQIP projects are implemented, physicians are often the last to be involved in many improvement initiatives that examine the total continuum of care at a facility, Dr. Fortune says. "It's not that they don't want to be involved, it's the reality that the administration, utilization and quality personnel in the hospital are really the ones monitoring the day-to-day process activities."

However, the quality improvement burden is not just on the physician, he says, "It's on the whole continuous quality improvement process, which ultimately

Continued on page 114

Developing an Improvement Plan

When you work with the HCQIP team on a cooperative project, your facility will be requested to produce an improvement plan with the following elements:

1. **Statement of underlying cause of area of concern.**
2. **Expected measurable outcome (goals).**
3. **Specific actions that will be taken to correct the problem.**
4. **Time frame for initiating and completing the plan.**
5. **Internal process to be used to ensure resolution.**
6. **Name of facility contact person.**

Continued from page 113

crosses many departmental lines. The projects serve to bridge the gaps between departments and help bring the physicians into the process."

The HCQIP program continues to enjoy these successes while debates over the future of Medicare continue in Washington. "As the volume of individual case review has dropped precipitously over the past two years, so has the correspondence going to individual physicians and hospitals," says Dan Jaco, MPCRF Chief Executive Officer. "This tends to reinforce the perception among some physicians that the PRO program is being phased out, and, in a traditional sense, it is."

Jaco notes that the biggest indication that MPCRF's focus on quality improvement is here to stay is that the Health Care Financing Administration (HCFA) has sent the Foundation a noncompetitive request for proposal for a new three-year contract to take effect this October.

"Our role in helping to maintain and improve quality of care for Medicare beneficiaries has assumed perhaps even greater importance in the context of reductions in the rate of Medicare expenditures between now and the end of the century," Jaco says. "Not only does QIO/PRO funding derive from the Medicare Trust Fund, the federal government has encumbered the program funds through 1999."

Jaco is enthusiastic about the value of HCQIP even if its federal funding were to be reduced in the future. "HCQIP is a terrific bargain and an outstanding resource in the state," he says. "We encourage physicians and hospitals to take advantage of it." **MoMed**

HCQIP collaborative project Q&A:

What happens when my facility decides to collaborate?

MPCRF provides information about the purpose of the project and analysis of the available data pertinent to the issue being studied. A facility's individualized data is collected using a ***Project Data Collection (PDC)*** tool, which is a questionnaire that extracts specific pieces of data from medical records. This data provides a ***baseline analysis*** (conducted by MPCRF or the provider) that more fully reflects your facility's performance on an improvement issue.

What's an improvement plan?

It simply maps out how your facility will address the issues you've uncovered. Improvement plans differ from hospital to hospital. In most projects, providers are asked to attach as much objective data as possible to support their improvement efforts.

How does a facility know that the cooperative project was a success?

MPCRF offers the following services to monitor the effectiveness of improvement plans:

Monthly data collection (if applicable for the project, collected by the provider)

Monthly status reports (provided by facility to MPCRF)
Hospitals select the options that most suit their needs. The size and scope of improvement plans are tailored to the individual facility and may involve multiple departments and personnel.

How does MPCRF measure a facility's long-term improvement after a cooperative project?

After a facility implements its improvement plan, the HCQIP staff begins ***post project monitoring***, which determines if a meaningful improvement has taken place. The ultimate goal is to help facilities foster their own improvement programs and learn techniques that can be widely employed throughout the facility.

Want to learn more? Call MPCRF at 1-800-735-6776.

(**Author's note**: This month we provide examples of MPCRF's collaborative quality improvement projects and their impact on Missouri providers. See last month's *Missouri Medicine* for an overview of how Medicare peer review has shed its random-sample case review function.)

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☐ Hospital Confinement Indemnity
☐ Yes, send me a personalized proposal. My date of birth is ____________

Mail to:
Sedgwick James of Missouri, Inc.
2420 Pershing Rd., Suite 220
Kansas City, MO 64108
Attn: Lisa Winchester

Name ____________________
Address ____________________
City ____________________ State ______ Zip __________
Phone (______) ____________________
Date of Birth ____________________

Preparing a Per-Member-Per-Month Capitated Bid to a Managed Care Plan

Gary M. White, CPA, MBA

This article outlines a process whereby a practice may analyze data to prepare a per-member-per-month capitated bid to a managed care plan. The methodology utilizes a spreadsheet analysis, including available data such as Medicare Relative Value Units, the practice's charge master, and published Medicare allowable rates. This approach assumes the practice has access to the managed care plan's utilization data.

Specialty Capitation RFP

This is how our practice recently responded to a Request For Proposal (RFP) for a cardiology specialty capitation rate. The managed care plan submitted an RFP in the late fall of 1995 to several cardiology groups in the metropolitan Kansas City area. This RFP requested a per-member-per-month (PMPM) bid from each practice. The managed care plan was then going to select certain practices for inclusion into their cardiology specialty network based upon a number of factors, including the per-member-per-month bid.

Utilization Data

The plan did share the number of members in their plan in the metropolitan area, in addition to utilization information by CPT code for the most recent year. This was all of the information available to each practice to arrive at a PMPM rate. While the analysis performed for our practice is specific to cardiology, the process involved in developing a PMPM rate can be used by any physician practice.

Information Needed

The process requires that you have access to the following items: (a) Any PC spreadsheet such as Lotus 1-2-3, Microsoft Excel, Borland QuattroPro, etc. You may also use your Microsoft Works spreadsheet installed in many original IBM-compatible personal computers. (b) Your Medicare Part B *Locality Fee Schedule Report* from the Department of Health and Human Services which lists the Medicare participating fee for each CPT code. (c) A copy of the Medicare *Resource-Based Relative Value System* (RBRVS) which lists the most current Relative Value Units (RVUs). This is available through the Federal Register or through several other sources such as the American Medical Association, (d) You will also need your own practice's current charge master.

Spreadsheet Layout and Calculations

Utilizing one of the computerized spreadsheets above, you need to set up the following columns: A: CPT; B: Description; C: Volume; D: RVU; E: Practice Charge; F: Medicare Allowable; G: Total RVU (C times D); H: Total Practice Charge (C times E); I: Total Medicare Allowable (C times F). Utilizing this spreadsheet layout, we headed the schedule "Capitation Worksheet." In column A: CPT, we listed every CPT code provided by the managed care plan. In column B, the description was entered. Column C included the utilization for each CPT code. For column D, Relative Value Units, we utilized the American Medical Association Medicare *RBRVS: Physician's Guide.* The RVU was entered in the computer spreadsheet for each CPT-4 code. Under column E, we listed the practice charge for each one of the CPT-4 codes, along with the Medicare allowable in column F from the Medicare Part B *Locality Fee Schedule Report* participating fee. With this basic data, we then utilized the spreadsheet software to calculate the total Relative Value Units in column G (column C: Volume x column D: RVU).

CAPITATION WORKSHEET

	A	B	C	D	E	F	G	H	I
1						Medicare	Total	Total	Ttl Medicare
2	CPT	Description	Vol.	RVU	Charge	Allowable	RVU	Charge	Allowable
3							(C x D)	(C x E)	(C x F)
4									
5	99242	office consult	27	1.99	$120.00	$67.08	53.73	$3,240.00	$1,811.16
6	99243	office consult	75	2.57	155.00	86.40	192.75	11,625.00	6,480.00
7	99244	office consult	115	3.60	216.00	121.39	414.00	24,840.00	13,959.85
8	99245	office consult	57	4.86	220.00	163.60	277.02	12,540.00	9,325.20
9	99251	init inpt consult	2	1.31	79.00	43.86	2.62	158.00	87.72
10	99252	init inpt consult	19	2.00	120.00	67.44	38.00	2,280.00	1,281.36
11	99253	init inpt consult	67	2.64	159.00	88.83	176.88	10,653.00	5,951.61
12	99254	init inpt consult	53	3.62	218.00	121.78	191.86	11,554.00	6,454.34
13	99255	init inpt consult	54	4.90	294.00	164.99	264.60	15,876.00	8,909.46
14	99262	f/u inpt consult	1	1.26	none	42.13	1.26	0.00	42.13
15	99263	f/u inpt consult	1	1.89	none	63.42	1.89	0.00	63.42
16	99273	confirmatory conslt	1	2.34	140.00	78.87	2.34	140.00	78.87
17	99283	er visit eval/mgmt	3	1.62	98.00	55.66	4.86	294.00	166.98
18	99284	er visit eval/mgmt	2	2.47	149.00	84.94	4.94	298.00	169.88
19	99285	er visit eval/mgmt	2	3.88	233.00	133.52	7.76	466.00	267.04
20	99291	critical care 1st h	7	5.24	315.00	176.26	36.68	2,205.00	1,233.82
21	99292	criticl care-adl 30	1	2.54	153.00	85.39	2.54	153.00	85.39
22	99302	nurs faclty assmt-e	1	2.24	none	77.01	2.24	0.00	77.01
23	99311	subs nrs fac care e	7	0.92	56.00	31.63	6.44	392.00	221.41
24	99313	subs nrs fac care e	1	1.71	103.00	58.85	1.71	103.00	58.85
25	99499	unlstd eva/mgmt svc	1	0.00	none	none	0.00	0.00	0.00
26	TOTAL						1,684.12	$96,817.00	$56,725.50
27									
28	GRAND TOTAL						14,934.25	$1,426,953.00	$482,256.29
29									
30		RVU/PMPM					660,000		
31							0.02262765		
32									
33		CHARGES/PMPM						660,000	
34								$2.16	
35									
36		MEDICARE ALLOWABLE/PMPM							660,000
37									$0.73
38		Practive Cost/RVU					$44.00		
39									
40		Cost/PMPM					$1.00		
41		($44.00 x .0226277)							
42									
43					Page 3 of 3				

We then arrived at a grand total of the Relative Value Units, or estimate of equivalent practice work output, for this managed care plan. The total practice charges that are based upon the CPT-4 codes and volumes supplied by the managed care plan are calculated by multiplying column C: Volume x column E: the practice's charge.

Estimating Minimum and Maximum Fee Ranges

Utilizing the same methodology, calculate the total Medicare allowables in column I, by multiplying column C: Volume x column F, the Medicare allowable. The spreadsheet can also calculate the

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grand totals for the total practice charges and the total Medicare allowables.

At this point, the reviewed data gives the grand total of Relative Value Units, or work output, represented by the utilization data made available by the managed care plan. We also calculated total practice gross billings based upon that utilization, as well as the total Medicare allowables used as a baseline to determine a per-member-per-month financial bid.

Developing Per-Member-Per-Month Rates

The next step in this process is to take the number of members in the managed care plan and multiply that number x 12 months to get total member months for the year. This figure, divided by the Relative Value Units, gives you an RVU per-member-per-month. I will return to the RVU/PMPM number later, as it can be interfaced with your practice's cost data (if you have this available) to arrive at a practice cost per-member-per-month estimate for this plan.

The per-member-per-month figure (number of managed care plan members x 12 months) is divided into the total practice charges from column H to arrive at a practice charge per-member-per-month. From the total of column I, representing the total Medicare charges, the same managed care annual membership number used in the RVU and practice charge columns is divided into the grand total Medicare allowable to arrive at a Medicare allowable per-member-per-month figure. You then have two numbers from the managed care utilization data which represent a potential maximum charge per-member-per-month from the practice and a baseline, or potential minimum, charge PMPM based upon Medicare rates. Although not covered in this article, the third component in bracketing the ranges is to develop a practice cost per-member-per-month utilizing the total Relative Value Units (a proxy for work output) divided by the total managed care membership units for the year mentioned earlier, thereby arriving at an RVU per-member-per-month. This number multiplied by your practice's cost per RVU will give you a practice cost per-member-per-month. As stated earlier, developing an RVU-based cost system for your practice can be done internally without a significant amount of work. The methodology to accomplish this will be the subject of a future article.

Determining the PMPM Bid

Finally, in the practice you have three numbers (gross charges per-member-per-month; Medicare allowable per-member-per-month; and actual practice cost per-member-per-month) to assist you in deciding a per-member-per-month rate to respond to the Request For Proposal (RFP). You will also want to take into account several subjective factors, such as (a) your estimate of the number of competitors in your specialty in your geographic area; (b) the relative size and strength of your practice vis-a-vis the competing practices; (c) the relative strength of the hospitals you are affiliated with and their importance to the managed care plan; (d) if you are a specialty practice, it would be helpful to contact your primary care referring physicians currently in the managed care plan to obtain letters of recommendation; (e) evaluate the importance to your practice of participating in this particular managed care plan and consider your bid accordingly. While there are other subjective factors in addition to the actual per-member-per-month bid, these should be the most significant.

Utilizing the above process, your practice should be able to make a more informed response to any Request For Proposal. It is also very important for your practice to monitor each managed care capitated contract on a monthly and year-to-date basis, calculating the Relative Value Units and charges to determine the level of practice profitability from the agreement. If utilization varies significantly in the future, you have data to discuss further with the managed care plan the validity of the per-member-per-month rates and may have the possibility to have adjustments made.

The Author

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REPORT OF MISSOURI STATE MEDICAL ASSOCIATION

December 31, 1995
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Council of
Missouri State Medical Association:

We have audited the accompanying Balance Sheets of Missouri State Medical Association as of December 31, 1995 and 1994, and the related Statements of Revenues, Expenses, and Changes in Members' Equity and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We did not examine the Financial Statements of MOMED Holding Company at December 31, 1995 and 1994. These Financial Statements were audited by another firm.

These Financial Statements are not in accordance with Generally Accepted Accounting Principles, which require investments in the subsidiary and the affiliate to be consolidated with the controlling entity.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, except for the above comments, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association as of December 31, 1995 and 1994, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

Our audits were made for the purpose of forming an opinion on the basic Financial Statements taken as a whole. The Schedules of Selected Expenses for the years ended December 31, 1995 and 1994 are presented for purposes of additional analysis and are not a required part of the basic Financial Statements. Such information has been subjected to the auditing procedures applied in the audit of the basic Financial Statements and, in our opinion, is fairly stated in all material respects in relation to the basic Financial Statements taken as a whole.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1996

BALANCE SHEETS
December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash and Cash Investments (Note 2)	$ 294,787	$ 495,345
Marketable Securities (Note 3)	1,317,430	1,608,476
Accounts Receivable	39,730	33,425
Other Current Assets	4,816	6,244
Total Current Assets	1,656,763	2,143,490
INVESTMENTS		
Common Stock of MOMED Holding Company, a 10.8% owned Affiliate, lower of cost or market (Note 5)	169,295	169,295
Common Stock of Missouri State Medical Services, Inc. (Note 13)	(149,628)	(95,039)
Common Stock of MSMI, Inc., a 100% owned unconsolidated Subsidiary, at cost plus equity in undistributed net income (Note 4)	35,288	33,815
Total Investments	54,955	108,071
LAND, BUILDING AND EQUIPMENT (Note 6)	495,249	494,728
OTHER ASSETS		
Cash Surrender Value - Insurance	24,058	102,447
Note Receivable, Missouri State Medical Services, Inc. (Note 14)	185,630	150,497
Interest Receivable, Missouri State Medical Services, Inc.	16,702	0
Total Other Assets	226,390	252,944
TOTAL ASSETS	$2,433,357	$2,999,233
LIABILITIES AND MEMBERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 10,034	$ 29,628
Due to the American Medical Association	197,840	109,497
Deferred Revenue	230,594	149,543
Total Current Liabilities	438,468	288,668
SUBORDINATED NOTES PAYABLE (Note 7)	0	590,781
DEFERRED COMPENSATION (Note 8)	15,000	73,500
Total Liabilities	453,468	952,949
MEMBERS' EQUITY	1,979,889	2,046,284
TOTAL LIABILITIES AND MEMBERS' EQUITY	$2,433,357	$2,999,233

The Notes to Financial Statements are an integral part of these Statements.

MSMA Financial Statements

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN MEMBERS' EQUITY

For the Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Dues	$1,184,433	$1,224,747
Subscriptions	17,711	16,005
Exhibit Rentals	33,700	15,000
Advertising	45,318	53,553
Commissions on Collections	14,329	14,635
Investment Income (Note 9)	263,667	109,708
Administrative Fees and Office Rent (Note 10)	55,848	45,704
Seminars and Workshops	13,585	24,440
Physicians Health Foundation (Note 11)	141,475	99,950
Royalties (Note 15)	60,659	53,820
Other Revenue	39,835	31,333
Total Revenues	1,870,560	1,688,895
EXPENSES		
Salaries and Fringe Benefits	762,881	839,035
Office Expense (Note 16)	132,355	106,554
Travel Expense	11,498	14,559
Commissions and Committee Expense	7,459	18,072
Depreciation	30,455	37,315
MSMA Auxiliary	9,353	10,081
Journal Expense	95,635	106,136
Meeting Expense	247,782	235,397
Public Affairs	91,604	54,321
Consultant and Professional Fees	69,520	106,789
Public Relations Program	29,998	29,686
Student Awards	1,200	1,200
Tort Reform	5,000	4,638
Miscellaneous	7,706	6,680
Seminars and Workshops	16,817	26,047
Physicians Health Foundation (Note 11)	172,228	161,969
MSMA Health Education Foundation	187,870	18,390
Medical Research Center	0	15,000
Physicians Guides to Law & Medicine	0	33,012
Missouri State Medical Foundation	161	0
Excess Subordinated Notes	4,317	0
Total Expenses	1,883,839	1,824,881
Excess (Deficiency) of Revenues Over Expenses Before Equity in Net Income of Investments	(13,279)	(135,986)
Equity in Subsidiary of MSMI, Inc. (Note 4)	1,473	(1,020)
Equity in Subsidiary of MSMS, Inc.	(54,589)	(125,039)
Excess (Deficiency) of Revenues Over Expenses	(66,395)	(262,045)
MEMBERS' EQUITY, BEGINNING	2,046,284	2,308,329
MEMBERS' EQUITY, ENDING	$1,979,889	$2,046,284

STATEMENTS OF CASH FLOWS

For the Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES	$ (66,395)	$(262,045)
ADJUSTMENTS TO RECONCILE EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Depreciation	30,455	37,315
Loss on Disposal of Equipment	879	0
(Increase) or Decrease to Accounts Receivables	(6,305)	(24,858)
(Increase) or Decrease in Other Current Assets	1,428	3,428
(Increase) or Decrease in Cash Surrender Value	78,389	(19,659)
(Increase) or Decrease in Note Receivable, MSMS, Inc.	(35,133)	(150,497)
(Increase) or Decrease in Interest Receivable, MSMS, Inc.	(16,702)	0
Increase or (Decrease) in Accounts Payable	(19,594)	18,054
Increase or (Decrease) in Due to the AMA	88,343	(78,243)
Increase or (Decrease) in Deferred Revenue	81,051	(68,329)
Increase or (Decrease) in Deferred Compensation	(58,500)	6,753
Net Cash Provided (Used) Operations	77,916	(538,081)
CASH FLOW FROM INVESTING ACTIVITIES:		
(Increase) or Decrease in Marketable Securities	291,046	(456,105)
(Increase) or Decrease in MSMI, Inc. Investment	(1,473)	1,020
(Increase) or Decrease in MSMS, Inc. Investment	54,589	95,039
Purchase of Equipment	(31,855)	(6,218)
Net Cash Provided (Used) by Investing Activities	312,307	(366,264)
CASH FLOW FROM FINANCING ACTIVITIES		
Decrease in Subordinated Notes Payable	(590,781)	0
Net Cash (Used) by Financing Activities	(590,781)	0
NET INCREASE OR (DECREASE) IN CASH	(200,558)	(904,345)
CASH AT BEGINNING OF YEAR	495,345	1,399,690
CASH AT END OF YEAR	$ 294,787	$ 495,345

The Notes to Financial Statements are an integral part of these Statements.

NOTES TO FINANCIAL STATEMENTS
December 31, 1995 and 1994

Note 1. Summary of Significant Accounting Policies

Organization:
The Missouri State Medical Association was incorporated as a not-for-profit corporation under the laws of the State of Missouri. The Internal Revenue Service has granted exemption under Code Section 501(c)(6).

Basis of Accounting:
The Financial Statements of the Missouri State Medical Association are prepared on the Accrual Basis of Accounting.

Dues:
Dues are assessed to members on a calendar-year basis. On December 31st of each year, members delinquent in payment of dues forfeit their memberships. The Association may also collect from members dues and assessments of the American Medical Association and County Medical Societies which are then forwarded to the respective organizations. The Association receives a fee for providing this service. Amounts received from members prior to January 1st of each year, which represents the subsequent year's dues, are recorded as Deferred Revenue.

Valuation of Accounts Receivable:
Accounts receivable are stated at face amount with no allowance for doubtful accounts. An allowance for doubtful accounts is not considered necessary because probable uncollectible accounts are immaterial.

Marketable Securities:
Investments in marketable equity securities are carried at the lower of aggregate cost or market at the Balance Sheet date.

Property and Equipment:
Property and equipment are carried at cost. Depreciation is computed by the straight-line method based on estimated useful lives of the related assets.

Income Taxes:
The Association is exempt from Federal Income Taxes under the Internal Revenue Code Section 501(c)(6). Any unrelated business income is subject to income tax.

Note 2. Cash and Cash Investments

The balance of cash and cash investments consisted of the following at December 31st:

	1995	1994
Petty Cash	$ 50	$ 50
Cash in Bank, Executive Vice President Account	6,178	8,110
Cash in Bank, Treasury Account	170,879	31,620
Money Market Fund	117,680	266,565
Certificates of Deposit	0	189,000
TOTAL CASH	$294,787	$495,345

Note 3. Marketable Securities

Investments in marketable equity securities are carried at the lower of aggregate cost or market at the Balance Sheet date.

The following is a summary of marketable equity securities at December 31st:

	1995	1994
Aggregate Cost	$1,317,430	$1,608,476
Aggregate Market	1,738,958	1,675,646
UNREALIZED GAIN	$ 421,528	$ 67,170

Net realized gain of $149,890 and $16,055 on the sale of marketable equity securities were included in revenue for the years ended December 31, 1995 and 1994, respectively.

Note 4. Investments in Unconsolidated Subsidiary - MSMI, Inc.

The Association's investments in MSMI, Inc., a 100% owned unconsolidated subsidiary, is carried at cost $2,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1995 and 1994, the investment in the subsidiary is carried at $37,288 and $35,815 respectively.

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	---December 31---	
	1995	1994
ASSETS		
CURRENT ASSETS		
Cash, including Savings Account	$ 22,288	$ 20,815
Total Current Assets	22,288	20,815
INVESTMENTS - COMMON STOCK	15,000	15,000
TOTAL ASSETS	$ 37,288	$ 35,815
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 2,000	$ 2,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value: 3000 shares authorized; 200 shares issued and outstanding	2,000	2,000
Retained Earnings	33,288	31,815
Total Stockholders' Equity	35,288	33,815
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 37,288	$ 35,815

STATEMENTS OF INCOME AND EXPENSES

	1995	1994
Income	$ 4,821	$ 2,275
Expenses	3,348	3,295
NET INCOME (LOSS)	$ 1,473	$ (1,020)

Note 5. Investment in Affiliate

At January 1, 1994, the Association exercised significant management control over its affiliate MOMED Holding Company, owner of Missouri Medical Insurance Company (MOMEDICO), a mono-line medical professional liability insurance company founded and sponsored by the Association.

Note 5. Investment in Affiliate (Continued)

On August 16, 1994, Missouri State Medical Association exchanged 24,185 shares of MOMED Holding Company's authorized and outstanding Class B common stock for 24,185 shares of MOMED Holding Company's Class A common stock (500,000 shares authorized), and 24,185 shares of its then newly issued Class C common stock.

The Class A common stock has the same rights as all other issued and outstanding shares of MOMED Holding Company's Class A common stock.

The MOMED Holding Company's Class C common stock is non-voting. MOMED Holding Company has agreed to acquire these 24,185 shares over the next four years at $24.81 per share. Aggregate cash consideration excluding interest will then be $600,000.

As a result of the aforementioned share exchange during 1994, the Association does not exercise significant management control over MOMED Holding Company at December 31, 1994 NCR at December 31, 1995. Market Value at both December 31, 1994 and 1995 was $169,295 (24,185 shares at $7.00 per share).

Most recently available condensed financial data relating to MOMED Holding Company follows:

At December 31, 1994--	
Missouri Medical Insurance Company per annual statement submitted to the Insurance Department of the State of Missouri	$63,849,250
Surplus as regards policy holders	14,245,895
Change in surplus as regards policy holders for the year	1,758,751

Note 6. Land, Building and Equipment

Consists of the following at December 31st (at Cost):

	1995	1994
Land	$ 83,000	$ 83,000
Building	581,704	581,704
Furniture and Equipment	244,362	316,087
Total	909,066	980,791
LESS: Accumulated Depreciation	413,817	486,063
TOTAL LAND, BUILDING AND EQUIPMENT	$495,249	$494,728

Note 7. Subordinated Notes Payable

In 1978, the Association formed a wholly-owned subsidiary, MOMEDICO, to provide professional liability and premises liability insurance for physicians and support technicians practicing in the State of Missouri. Before obtaining professional liability insurance through MOMEDICO, physicians residing in the State of Missouri were required to subscribe to non-interest bearing subordinated notes based upon the physician's under- writing classification. These notes were issued by the Association and the subscriptions were payable over a three-year period.

The Association was the sole stockholder of MOMEDICO prior to public stock offering of MOMEDICO in 1980. At that time, the requirement to purchase subordinated notes was eliminated with new policies effective January 31, 1980.

In connection with the public stock offering in 1980, MOMEDICO assumed, in exchange for 100,815 of the 125,000 shares of the Class B common stock the Association held in MOMEDICO, the face value of the subordinated notes issued and outstanding. MOMEDICO also assumed the balance of the installments receivable on the subordinated notes and a bank note payable from the Association.

Under an exchange offer made by MOMEDICO, holders of the Association's subordinated note could exchange fully paid notes for Class A common stock at the rate of $20 face value per share.

On October 15, 1980, the Association reassumed all notes not exchanged and also the installments receivable on the unexchanged notes as well as an amount equal to the installments receivable of the bank note payable.

The notes require repayment only upon the Association's accumulation of an excess of $3,000,000 of Members' Equity at the end of any calendar year, that the Association has sufficient funds and assets, exclusive of the amount subject to repayment, and that repayment be approved by the Council of the Association. Interest may be paid on the notes, but it is at the discretion of the Council of the Association.

Redemption of the notes are provided for in the event of death, disability, retirement of the holder, or if the holder has moved both his person and his practice out of the State of Missouri. However, redemption for such causes may be delayed or refused if the Council determines the Association is not on a financially reasonable basis to make such redemptions.

At December 31, 1994 the balance for the subordinated notes payable were $590,781. This amount reflects the face value of the notes reassumed by the Association on October 15, 1980, less the installments receivable on the outstanding notes, and less all redemp- tions made from 1981 through 1985. In 1985, the Council of the Association placed a moratorium on the redemption of the subordinated notes.

On August 10, 1995, Missouri State Medical Association transferred approximately $590,000 to an earlier established irrevocable Missouri State Medical Association Trust included the mandate to satisfy all subordinated notes payable to member physicians. Any monies remaining, after a two year period, are to be donated to the Missouri State Medical Foundation.

Note 8. Deferred Compensation Plan

The Association entered into a deferred compensation agreement with its Executive Vice-President on December 31, 1980, which provides for payments upon retirement, death or disability. The agreement also stipulates that a pro-rata settlement of benefits will be made in the event of voluntary termination of employment with the Association once five years of service is completed after the agreement becomes effective. A similar agreement was enacted May 1, 1992 between the Executive Director and the Association. Both agreements are funded through insurance policies.

At December 31, 1995 and 1994, the Association's liability under the terms of these agreements were $0.00 and $73,500, respectively with the underlying cash surrender value of life insurance being $24,058 and $102,447, respectively.

On December 17, 1989, the Association adopted a Deferred Compensation Plan for employees pursuant to Internal Revenue Service Code Section 457. Within Internal Revenue Service guidelines, participants may elect to defer a portion of their income until retirement. Funds invested for these purposes amounted to $158,821 and $122,271 as of December 31, 1995 and 1994, respectively.

Subsequent to the year-ended December 31, 1994, the Executive Vice President retired, with the Executive Director assuming the position of Executive Vice President on January 1, 1995.

Note 9. Investment Income

The following is a summary of investment income for the years ended December 31st:

	1995	1994
Interest on Cash Investments	$ 28,210	$ 38,284
Dividends	64,072	55,369
Realized Gain or (Loss) on the Sale of Marketable Equity Securities	149,890	16,055
Interest on Note to Subsidiary	21,495	0
TOTAL INVESTMENT INCOME	$263,667	$109,708

Note 10. Related Party Transactions

The Association provides administrative services to MSMI, Inc., (a wholly-owned subsidiary) and Missouri State Medical Foundation (an affiliate). For providing these services, the Association receives an annual fee from each of these two organizations. For the years ended December 31, 1995 and 1994, the annual administrative fee assessed to Missouri State Medical Foundation was $18,000 and $15,000 respectively, and the administrative fee assessed to MSMI, Inc., was $2,000 annually.

Note 11. Physicians Rehabilitation Program

In 1986, the Association established a Physicians Rehabilitation Program, the purpose of which is to motivate impaired physicians to voluntarily enter into treatment and to provide such a treatment program.

Funding for the program is provided by fees assessed to participants as well as from donations received from supportive individuals and organizations.

During 1992, the Missouri State Medical Association Physicians Health Foundation was separately incorporated. For the years ended December 31, 1995 and 1994, the Association received as income $141,475 and $99,950 from the Physicians Health Foundation and in turn paid expenses of $172,228 and $161,969, respectively. The resulting differences of $30,753 and $62,019 are considered in-kind contributions to the Physicians Health Foundation for the years ended December 31, 1995 and 1994.

Note 12. Pension Plan

The Association maintains a non-contributory Defined Benefit Pension Plan covering substantially all of its employees. Established April 1, 1959, the Plan has a March 31st year end. Eligibility requirements include a minimum of 12 service months and a minimum age of 21. Normal retirement age is 65 with provision for pro-rata benefits prior to 65. Vesting is scheduled over six years of covered service. The Individual Aggregate Actuarial Cost Method is used as the basis for the funding standard account computation. At March 31, 1995, the most recently available actuarial information, fair value of plan assets was $343,616 and $855,008, in 1994. Total benefit obligation was $1,108,229, $707,971, in 1994 with a vested benefit obligation of $1,096,969, $704,125, in 1994.

Employer contributions for FYE March 31, 1995 was $115,526, $88,597 in 1994. Additional Plan income was $12,111, $49,200 in 1994, with expenses of $203 in 1994, and benefits paid in the amount of $638,835, $231,244 in 1994, and net income (loss) for the Plan year was $(511,392), $(96,500)in 1994. There was no unconditional liability for any unfunded accumulated benefit obligation plus any prepaid pension cost, nor unfunded accumulated benefit obligation reduced by any unfunded accrued pension cost. Assets are invested primarily in government securities and corporate stocks and bonds.

Net periodic pension costs for 1995 of $117,583, $90,491 in 1994, was composed of employer's normal cost of $107,131, $83,555 in 1994, Amortization charge of $233, $233 in 1994, and interest of $8,589, $6,703 in 1994.

On January 1, 1995, the Executive Vice President retired, with the Executive Director assuming the position of Executive Vice President on January 1, 1995.

Note 13. Investment in Unconsolidated Subsidiary - MSMS, Inc.

The Association's investments in MSMS, Inc., a 100% owned unconsolidated subsidiary, is carried at cost of $30,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1995 and 1994, the investment in the subsidiary is carried at $(149,628) and $(95,039) respectively.

Note 13. Investment in Unconsolidated Subsidiary - MSMS, Inc. (Continued)

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash	$ 40,371	$ 42,916
LESS: Cash held in Trust for Others (Note 2)	0	(10,500)
Cash, Net	40,371	32,416
Accounts Receivable (Note 1)	14,746	24,737
Employee Advances	500	1,500
Total Current Assets	55,617	58,653
PROPERTY AND EQUIPMENT (Note 1)		
Office Furniture and Equipment	3,460	4,665
LESS: Accumulated Depreciation	1,038	467
Total Property and Equipment	2,422	4,198
TOTAL ASSETS	$ 58,039	$ 62,851
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$185,630	$150,497
Accounts Payable	2,735	0
Accrued Expenses	2,600	2,600
Interest Payable	16,702	4,793
Total Current Liabilities	207,667	157,890
STOCKHOLDERS' EQUITY		
Common Stock, $1 par value: 30,000 Shares authorized; 30,000 Shares issued and outstanding	30,000	30,000
Retained Earnings	(179,628)	(125,039)
Total Stockholders' Equity	(149,628)	(95,039)
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 58,039	$ 62,851
STATEMENTS OF INCOME AND EXPENSES		
Income	$166,509	$ 88,469
Expenses	221,098	213,508
NET INCOME (LOSS)	$(54,589)	$(125,039)

Note 14. Note Receivable, Missouri State Medical Services, Inc.

The note represents monies advanced by Missouri State Medical Association to Missouri State Medical Services, Inc. For initial expenses. The note is a demand note in the amount of $185,630 and $150,497 at December 31, 1995 and 1994, respectively, with interest at the rate of 9.5% in 1995 and 7.75% in 1994. The interest rate adjusts annually on January 1st to the prime rate plus 1%.

Note 15. Royalties

Royalty income is received from Missouri Medical Insurance Co. for use of the Missouri State Medical Association name and various logos in the marketing and advertisement of its professional liability insurance and risk management products. For the year ended December 31, 1995 and 1994, royalty income received from Missouri Medical Insurance Co. was $35,000 and $30,000 respectively.

An additional royalty of $20 per Missouri Medical Insurance Co. insured physician in the State of Missouri as of December 31st of each preceding year, is to be paid on or before February 15th of the following year. At December 31, 1995 and 1994, royalty income receivable totaled $22,180 and $23,820 respectively.

Note 16. Operating Lease - Automobile

The following is a schedule, by year, of future minimum rental payments required under an operating lease for the rental of an automobile that has an initial or remaining noncancelable lease term in excess of one year as of December 31, 1995:

Years ending December 31st:

1996	$6,149
1997	1,537
Total	$7,686

Total rental expense for the year ending December 31, 1995, totaled $5,177.

ACCOMPANYING INFORMATION

SCHEDULES OF SELECTED EXPENSES
For the Years Ended December 31, 1995 and 1994

	1995	1994
SALARIES AND FRINGE BENEFITS		
Salaries	$474,412	$572,036
Payroll Taxes	38,560	44,255
Employees Life and Disability Insurance	13,846	15,646
Employees Hospitalization Insurance	51,387	59,901
Employees Pension Plan Contribution	123,237	98,797
Deferred Compensation Plan Expense	46,439	48,400
TOTAL SALARIES AND FRINGE BENEFITS	$747,881	$839,035
OFFICE EXPENSES		
Occupancy Expense	$ 17,579	$ 16,365
Office Supplies	19,037	23,277
Computer Expense	6,672	7,538
Postage	21,691	10,883
Telephone	16,505	14,156
Insurance	9,156	(5,378)
General Expense	(2,554)	2,161
Taxes, Real Estate	3,994	4,435
Taxes, Other	942	752
Custodian Fee	14,957	14,349
Equipment Rental and Repair	14,505	8,487
Dues and Directories	9,871	9,529
TOTAL OFFICE EXPENSES	$132,355	$106,552

	1995	1994
COMMISSIONS AND COMMITTEES EXPENSES		
Commissions:		
Commission on Medical Economics, Third Party Medicine and Governmental Relations	$ 60	$ 158
Commission on Continuing Medical Education	7,049	9,869
Commission on Interspeciality Medicine	350	288
Total Commissions Expenses	7,459	10,315
Committee on Legislative Affairs	$ 0	$ 635
Committee on Public Affairs	0	154
Committee to Develop Physician Direction Organization	0	6,968
Total Committee Expenses	0	7,757
TOTAL COMMISSIONS AND COMMITTEE EXPENSES	$ 7,459	$ 18,072
MEETING EXPENSES		
Meetings:		
Annual Session	$ 67,531	$ 67,349
Council	75,436	62,893
AMA Delegates' Expenses	100,781	98,583
Student Section	1,396	1,927
Discretionary Council Fund	1,714	1,645
Hospital Medical Staff	924	3,000
TOTAL MEETING EXPENSES	$247,782	$235,397

MISSOURI MILITARY ACADEMY

- Safe, Caring, Disciplined, All-boys Boarding Program
- Students learn how to study and solve problems in supportive college prep; grades 9 - 12, PG
- Separate Jr. School, grades 4-8
- Supervised Study, Daily Extra Help
- On-line, Computer-networked campus on Internet and WWW
- 11 Varsity and 13 Intramural Sports
- Band, Vocal Music, Art, Drama, Riding, Aviation Programs
- Top-rated Army JROTC and ESL
- Corps of Cadets from 28 states and 8 countries
- First-class Facilities on beautiful 288-acre campus
- Fully Accredited by NCA and ISACS
- Immediate Enrollments and Campus Tours Available

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MSMF Financial Statements

REPORT OF
MISSOURI STATE MEDICAL FOUNDATION

December 31, 1995
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Foundation:

We have audited the accompanying Statements of Assets and Fund Balance-Modified Cash Basis of Missouri State Medical Foundation as of December 31, 1995 and 1994, and the related Statements of Revenues, Expenses and Changes in Fund Balance-Modified Cash Basis for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 1, these Financial Statements were prepared on the Modified Cash Basis of Accounting, which is a comprehensive basis of accounting other than Generally Accepted Accounting Principles.

In our opinion, except for the above comments, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Foundation as of December 31, 1995 and 1994, and the results of their operations and its cash flows for the years then ended on the basis of accounting described in Note 1.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1996

STATEMENTS OF ASSETS AND FUND BALANCE - MODIFIED CASH BASIS
December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash and Equivalents	$ 490,611	$ 523,237
Investments (Note 3)	707,856	560,899
Loans Receivable, Current (Note 4)	250,000	250,000
Accrued Interest	14,311	0
Total Current Assets	1,462,778	1,334,136
LONG-TERM ASSETS		
Loans Receivable, Long-term (Note 4)	1,442,321	1,412,812
Total Long-term Assets	1,442,321	1,412,812
EQUIPMENT		
Office Equipment, Net	1,613	1,858
Software, Net	8,905	6,052
Total Equipment	10,518	7,910
TOTAL ASSETS	$2,915,617	$2,754,858
FUND BALANCE		
FUND BALANCE	$2,915,617	$2,754,858

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCE - MODIFIED CASH BASIS
For the Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Interest on Student Loans	$ 145,219	$ 129,487
Investment Income	65,263	37,585
Contributions	95	2,858
Gain on Sales of Securities	(848)	14,255
Total Revenues	209,729	184,185
EXPENSES		
Administrative	18,000	15,000
Professional Fees	2,427	9,889
Printing and Meeting	814	748
Provision for Loan Losses	19,086	9,908
Depreciation	412	133
Amortization	1,685	103
Bank Fees	5,448	0
Miscellaneous	1,098	1,215
Total Expenses	48,970	36,996
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	160,759	147,189
FUND BALANCE, BEGINNING	2,754,858	2,607,669
FUND BALANCE, ENDING	$2,915,617	$2,754,858

The Notes to Financial Statements are an integral part of these Statements.

NOTES TO FINANCIAL STATEMENTS
December 31, 1995 and 1994

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Foundation was organized in 1961 for the purpose of making low-interest loans to medical students.

Basis of Accounting:

The accounts are maintained, and these Financial Statements are presented on, a Modified Cash Basis of Accounting. Under that basis, revenues are recognized when received rather than when earned, and expenses are recognized when paid rather than when incurred.

Investments:

Investments are stated at the lower of aggregate cost or market at the Balance Sheet date.

Loans Receivable:

Loans receivable are stated at face amount less an allowance for doubtful accounts of four percent of the loan balances at December 31, 1995 and three percent of loan balances at December 31, 1994.

Income Taxes:

The Foundation is qualified as an exempt organization under Section 501(c)(3) of the Internal Revenue Code and is not subject to Federal or State Income Tax.

Note 2. Cash and Equivalents

Cash and equivalents consist primarily of Cash and Government Issues with maturities of one year or less. Cash and equivalents are stated at cost plus accrued interest, which approximates market value.

Cash and equivalents includes the following accounts:

	1995	1994
Cash in Bank, Checking	$ 4,511	$ 17,916
Money Market	36,656	73,939
Government Issues, Bank	104,281	431,382
Taxable Bonds	345,163	0
TOTAL CASH AND EQUIVALENTS	$490,611	$523,237

Note 3. Investments

At December 31, 1995 and 1994, the Foundation's investments consist of Government Issues, Mortgage and Asset-backed Issues, and Taxable Bonds, all having maturities in excess of one year, and a Mutual Fund Portfolio. Government Issues and Bonds are stated at cost plus accrued interest, which approximates market value. Mortgage and Asset-backed Issues are stated at cost less principle payments made to date, to approximate market value. The Mutual Fund Portfolio is valued at cost plus reinvested interest and dividends.

Note 4. Loans Receivable

The following is a summary of the transactions affecting the loans receivable account for the year:

	1995	1994
Loans Receivable, Beginning of Year	$1,714,239	$1,783,962
New Loans	273,480	186,042
Principal Payments	(224,885)	(243,765)
Loans Written Off	0	(12,000)
LOAN RECEIVABLE, ENDING OF YEAR	$1,762,834	$1,714,239
Allowance for Doubtful Accounts, Beginning of Year	51,427	53,519
Current Year Provision	19,086	9,908
Loans Written Off	0	(12,000)
ALLOWANCE FOR DOUBTFUL ACCOUNTS, ENDING OF YEAR	$ 70,513	$ 51,427

Note 5. Equipment

Office equipment is recorded at cost and depreciated over its estimated useful life on a straight-line basis.

Intangible assets, such as software, are recorded at cost and amortized over a 60-month period on a straight-line basis.

	1995	1994
Equipment at Cost	$ 2,158	$ 1,991
LESS: Accumulated Depreciation	545	133
BOOK VALUE	$ 1,613	$ 1,858
Software at Cost	$10,692	$ 6,155
LESS: Accumulated Depreciation	1,787	103
BOOK VALUE	$ 8,905	$ 6,052

Note 6. Related Party Transactions

The Foundation is assessed by the Missouri State Medical Association an annual fee for administrative cost. For the years ended December 31, 1995 and 1994, the Foundation paid the Association $18,000 and $15,000 respectively, for administrative costs. The Foundation also reimburses the Missouri State Medical Association for expenses paid by the Association on behalf of the Foundation. This reimbursement for the year ended December 31, 1994 was $167 for printing and meeting expenses. There were no reimbursements made for such expenses for the year ended December 31, 1995.

NOTICE TO MSMA MEMBERS: The Annual Meeting of the Missouri State Medical Foundation will be held during the MSMA Annual Meeting. It is scheduled for 2:30 p.m., Friday, April 12, 1996, at Tan-Tar-A Resort.

MSMA Physicians' Health Foundation Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
PHYSICIANS' HEALTH FOUNDATION

December 31, 1995
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Physicians Health Foundation:

We have audited the accompanying Balance Sheets of Missouri State Medical Association Physicians Health Foundation as of December 31, 1995 and 1994, and the related Statements of Revenues, Expenses and Changes in Fund Balance for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Physicians Health Foundation as of December 31, 1995 and 1994, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1996

BALANCE SHEET
December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash	$ 6,659	$ 459
Accounts Receivable	6,905	2,350
Prepaid Expenses	840	840
Total Current Assets	14,404	3,649
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	6,339	6,339
LESS: Accumulated Depreciation	4,005	2,737
Total Property and Equipment	$ 2,334	$ 3,602
TOTAL ASSETS	16,738	7,251
FUND BALANCE	$16,738	$ 7,251
TOTAL LIABILITIES AND FUND BALANCE	$16,738	$ 7,251

The Notes to Financial Statements are an integral part of these Statements.

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCE
For the Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES (Note 2)		
Contributions, Cash	$ 91,211	$ 66,973
Contributions, In-kind (MSMA)	30,723	61,962
Service Fees	62,085	37,440
Total Revenues	184,019	166,375
EXPENSES		
Professional Services	120,700	114,674
Office Supplies	5,127	5,339
Travel Expenses	9,797	9,593
Telephone	6,995	5,767
Office Rent	3,360	3,360
Contracts Expense	24,960	16,660
Dues and Subscriptions	150	0
Education and Training	847	0
Miscellaneous	261	1,082
Bank Service Charge	472	411
Depreciation	1,268	995
Bad Debt Expense	595	0
Total Expenses	174,532	157,881
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	9,487	8,494
FUND BALANCE, BEGINNING	7,251	(1,243)
FUND BALANCE, ENDING	$ 16,738	$ 7,251

NOTES TO FINANCIAL STATEMENTS
December 31, 1995 and 1994

Note 1. Summary of Significant Accounting Policies

Organization:
Missouri State Medical Association Physicians Health Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on March 26, 1990.

The purpose of the Foundation is to support and promote quality professional health care through the sponsoring, supporting, initiating, funding, and establishing of the rehabilitation of chemically-dependent or mentally-impaired physicians.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:
The Financial Statements of Missouri State Medical Association Physicians Health Foundation are prepared on the Accrual Basis of Accounting.

Accounts Receivable:
Program service revenues are recognized when billed to participants and charged to accounts receivable. Accounts receivable are stated at face value with no allowance for doubtful accounts as all probable uncollectible accounts have been written off or considered immaterial.

Property and Equipment:
Property and equipment are carried at cost. The Foundation records depreciation on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:
The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Expense Classifications:
Certain expense categories previously reported separately for the year ended December 31, 1993 have been combined in the accompanying Financial Statements.

Note 2. Revenues

The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of operating expenses. Fees are also charged, in a nominal amount, to service recipients.

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MSMS, Inc. Financial Statements

REPORT OF
MISSOURI STATE MEDICAL SERVICES, INC.

December 31, 1995
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Services, Inc.:

We have audited the accompanying Balance Sheets of Missouri State Medical Services, Inc., as of December 31, 1995 and 1994, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Services, Inc., as of December 31, 1995 and 1994, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1996

BALANCE SHEET
For the Years Ended December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash	$ 40,371	$ 42,916
LESS: Cash Held in Trust for Others (Note 2)	0	(10,500)
Cash, Net	40,371	32,416
Accounts Receivable (Note 1)	14,746	24,737
Employee Advances	500	1,500
Total Current Assets	55,617	58,653
PROPERTY AND EQUIPMENT (Note 1)		
Office Furniture and Equipment	3,460	4,665
LESS: Accumulated Depreciation	(1.038)	(467)
Total Property and Equipment	2,422	4,198
TOTAL ASSETS	$ 58,039	$ 62,851
LIABILITIES AND STOCKHOLDER'S EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$ 185,630	$ 150,497
Accounts Payable	2,735	0
Accrued Expenses	2,600	2,600
Interest Payable	16,702	4,793
Total Current Liabilities	207,667	157,890
STOCKHOLDERS' EQUITY		
Common Stock, $1 par value: 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Retained Earnings	(179,628)	(125,039)
Total Stockholder's Equity	(149,628)	(95,039)
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 58,039	$ 62,851

STATEMENT OF INCOME
For the Years Ended December 31, 1995 and 1994

	1995	1994
INCOME		
Consulting Fees (Note 1)	$161.720	$ 80,744
Seminar Fees	2,261	7,250
Interest Income	1,408	475
Miscellaneous	1,120	0
Total Income	166,509	88,469
EXPENSES		
Salaries and Benefits	$ 133,995	$ 127,220
Meetings and Retreats	1,593	29,408
Travel and Entertainment	21,378	12,550
Rent	15,996	11,574
Telephone	10,165	8,504
Printing and Supplies	4,864	10,990
Contract and Professional Fees	14,817	5,259
Miscellaneous Expense	775	728
Provision for Bad Debts	0	2,015
Depreciation	813	467
Interest Expense	16,702	4,793
Total Expenses	221,098	213,508
NET INCOME (LOSS) BEFORE TAXES	(54,589)	(125,039)
Provision for Income Taxes	0	0
NET INCOME (LOSS)	$ (54,589)	$(125,039)

STATEMENT OF RETAINED EARNINGS
For the Year Ended December 31, 1995 and 1994

	1995	1994
BALANCE, BEGINNING	$(125,039)	$ 0
Net Income (Loss)	(54,589)	(125,039)
BALANCE, ENDING	$(179,628)	$(125,039)

The Notes to Financial Statements are an integral part of these statements.

STATEMENT OF CASH FLOWS
For the Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$ (54,589)	$(125,039)
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by Operating Activities:		
Depreciation	813	467
(Increase) in Accounts Receivable	9,991	(24,737)
(Increase) in Employee Advances	1,000	(1,500)
Increase in Accounts Payable	2,735	0
Increase in Accrued Expenses	0	2,600
Increase in Interest Payable	11,909	4,793
Net Cash Provided (Used) by Operating Activities	(28,141)	(143,416)
CASH FLOWS FROM INVESTING ACTIVITIES		
Acquisition of Property and Equipment	0	(4,665)
Sale of Property and Equipment	963	0
Net Cash Provided (Used) by Investing Activities	963	(4,665)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from Short-term Debt	35,133	150,497
Proceeds from Issuance of Common Stock	0	30,000
Net Cash Provided (Used) by Financing Activities	35,133	180,497
Net Increase (Decrease) in Cash	7,955	32,416
CASH, BEGINNING OF YEAR	32,416	0
CASH, END OF YEAR	$ 40,371	$ 32,416

NOTES TO FINANCIAL STATEMENTS
December 31, 1995 and 1994

Note 1.Summary of Significant Accounting Policies

Organization:

Missouri State Medical Services, Inc. was incorporated on February 2, 1994, under the laws of the State of Missouri. From inception to present, Missouri State Medical Services, Inc., was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501(c)(6).

The Company receives consulting fees for managerial and advisory services to physician practices. These fees represent substantially all of the Company's income. Additionally, the Company receives fees for presentations of seminars.

Basis of Accounting:

The Financial Statements of the Missouri State Medical Services, Inc., are prepared on the accrual basis of accounting.

Accounts Receivable:

Consulting fees are recorded as revenue and charged to accounts receivable after initial services have been provided and the clients have agreed to proceed with the engagement. Some services are provided initially that may not be charged to the client if no further engagement is agreed upon. Accounts receivable are stated at face amount with no allowance for doubtful accounts at December 31, 1995 and 1994, as all probable uncollectible accounts have been written off or are considered immaterial.

Property and Equipment:

Property and equipment are carried at cost. Depreciation is recorded on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:

The Company has an operating loss carryforward of $179,000 that may be offset against future taxable income. If not used, the carryforward will expire in the year 2010.

Note 2. Cash Held in Trust for Others

At December 31, 1994, the Company held in its operating account deposits totaling $10,500. These funds were received from various physicians or physician groups in the St. Louis area for the purpose of establishing a future Management Services Organization (MSO), which would be separate and autonomous from the Company. These funds were being held in trust by the Company and were disbursed or returned during 1995. The Company was not liable for interest payments on the funds.

Note 3. Related Party Transactions

Missouri State Medical Association is the parent corporation of Missouri State Medical Services, Inc.. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 30,000 shares of capital stock authorized, issued and outstanding of the Company.

The Company has a demand note payable to Missouri State Medical Association in the amount of $150,497 at December 31, 1995 and 1994 respectively, with interest at the rate of 9.50% in 1995 and 7.75% in 1994. The interest rate adjusts annually on January 1st to the Chase Manhattan prime rate plus 1%.

MSMA-HEF Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
HEALTH EDUCATION FOUNDATION

December 31, 1994
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Health Education Foundation:

We have audited the accompanying Balance Sheets of Missouri State Medical Association Health Education Foundation as of December 31, 1995 and 1994, and the related Statements of Revenues, Expenses and Changes in Fund Balance for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Health Education Foundation as of December 31, 1995 and 1994, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1995

BALANCE SHEET
December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash	$ 929	$ 1,724
Total Current Assets	929	1,724
TOTAL ASSETS	$ 929	$ 1,724
CURRENT LIABILITIES		
Accounts Payable	$ 6,651	$ 0
Total Current Liabilities	6,651	0
FUND BALANCE	(5,722)	1,724
TOTAL LIABILITIES AND FUND BALANCE	$ 929	$ 1,724

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCE
For the Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES (Note 2)		
Contributions, Cash	$ 21,358	$ 1,798
Contributions, In-kind (MSMA)	167,870	18,346
Total Revenues	189,228	20,144
EXPENSES		
Salaries and Wages	20,585	0
Payroll Taxes	1,569	0
Production Expenses	162,497	13,735
Professional Fees	3,669	1,000
Office Supplies	2,578	1,222
Travel and Meeting Expenses	4,447	270
Telephone	444	313
Dues and Subscriptions	0	618
Advertising	885	465
Miscellaneous	0	440
Other Supplies	0	357
Total Expenses	196,674	18,420
EXCESS DEFICIENCY OF REVENUES OVER EXPENSES	(7,446)	1,724
FUND BALANCE, BEGINNING	1,724	0
FUND BALANCE, ENDING	$ (5,722)	$ 1,724

The Notes to Financial Statements are an integral part of these Statements.

NOTES TO FINANCIAL STATEMENTS
December 31, 1994

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Association Health Education Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on July 25, 1994.

The purpose of the Foundation is to produce thirty (30) minute video tapes to be televised throughout the State of Missouri to educate the general public about health issues.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:

The Financial Statements of Missouri State Medical Association Health Education Foundation are prepared on the Accrual Basis of Accounting.

Income Taxes:

The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Note 2. Revenues

The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of the operating expenses.

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MSMI, Incorporated Financial Statements

REPORT OF MSMI, INCORPORATED

December 31, 1995
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
MSMI, Incorporated:

We have audited the accompanying Balance Sheets of MSMI, Incorporated as of December 31, 1995 and 1994, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of MSMI, Incorporated as of December 31, 1995 and 1994, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1996

BALANCE SHEETS
December 31, 1995 and 1994

	1995	1994
ASSETS		
CURRENT ASSETS		
Cash	$ 22,288	$ 20,815
Total Current Assets	22,288	20,815
INVESTMENTS - COMMON STOCK (Note 2)	15,000	15,000
TOTAL ASSETS	$ 37,288	$ 35,815
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 2,000	$ 2,000
Total Current Liabilities	2,000	2,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value: 3000 shares authorized; 200 shares issued and outstanding	2,000	2,000
Retained Earnings	33,288	31,815
Total Stockholders' Equity	35,288	33,815
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 37,288	$ 35,815

STATEMENTS OF INCOME
For the Years Ended December 31, 1995 and 1994

	1995	1994
INCOME		
Interest Income	$ 557	$ 585
Tour Commissions	4,264	1,690
Total Income	4,821	2,275
EXPENSES		
Bank Service Charge	48	55
Office Service (Note 3)	2,000	2,000
Professional Fees	1,117	1,200
Postage	32	0
Taxes, other	151	40
Total Expenses	3,348	3,295
NET INCOME (LOSS) BEFORE TAXES	1,473	(1,020)
Provision for Income Taxes	0	0
NET INCOME (LOSS)	$ 1,473	$ (1,020)

The Notes to Financial Statements are an integral part of these statements.

STATEMENTS OF RETAINED EARNINGS
For the Years Ended December 31, 1995 and 1994

	1995	1994
BALANCE, BEGINNING	$31,815	$32,835
Net Income (Loss)	1,473	(1,020)
BALANCE, ENDING	$33,288	$31,815

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$ 1,473	$(1,020)
Increase (Decrease) in Accounts Payable	0	(1,000)
Increase or (Decrease) in Cash	1,473	(2,020)
CASH, BEGINNING	20,815	22,835
CASH, ENDING	$22,288	$20,815

The Notes to Financial Statements are an integral part of these statements.

NOTES TO FINANCIAL STATEMENTS
December 31, 1994 and 1993

Note 1. Summary of Significant Accounting Policies

Organization:

MSMI, Incorporated was incorporated on December 11, 1974, under the laws of the State of Missouri. From inception to present, MSMI, Incorporated was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (c)(6).

The Company receives commissions on tours sold by a travel agency to members of the Missouri State Medical Association. These commissions represent substantially all of the Company's income.

Basis of Accounting:

The Financial Statements of the MSMI, Incorporated are prepared on the Accrual Basis of Accounting.

Note 2. Investments

The Company acquired 4,000 shares of Class A common stock of MOMED Holding Company (Originally Missouri Medical Insurance Company) on November 21, 1980. Investments in marketable equity securities are carried at the lower of aggregate cost or market at the Balance Sheet date. Market value of the shares at December 31, 1995 and 1994 was $28,000 and $28,000, respectively, resulting in an unrealized gain of $13,000 and $13,000, respectively.

Note 3.Related Party Transactions

Missouri State Medical Association is the parent corporation of MSMI, Incorporated. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 200 shares of capital stock issued and outstanding of the Company. All office services of the Company are provided or performed by the Association with a fee assessed for such services. For each of the years ended December 31, 1995 and 1994, this fee was $2,000 which was due to the Association on December 31, 1995 and 1994, respectively.

Attention Deficit Hyperactivity Disorder, Infantile Autism, and Elevated Blood-lead: A Possible Relationship

Thomas D. Eppright, MD, Julia A Sanfacon, BA, and Ellen A. Horwitz, PhD

This case involves a 4 ½-year-old boy diagnosed with autism, attention deficit hyperactivity disorder (ADHD), and an elevated blood-lead level of 42 mcg/dl. The child was treated for the elevated blood-lead with the chelating agent succimer. The parents reported a decrease in repetitive behaviors while on succimer with a regression to previous symptoms when medication was discontinued. Also seen was a decrease of hyperactive behavior while being treated with succimer. This article explores the interaction and possible casual relationship of an elevated blood-lead, autism, and ADHD as well as treatment of the behavioral symptoms.

Autism and attention deficit hyperactivity disorder (ADHD) are not well understood. The diagnostic tools used to assess these disorders are based on descriptive analysis. Proposed causal factors of these disorders range from environmental to neurological, but no one factor has proven to be conclusive.

Autism is more prevalent in males than females.[1] The differential diagnosis of autism is complex since the symptoms are shared by many other disorders and vary with developmental age and level of functioning.[2]

According to Rutter,[3] the prevalence of ADHD has been estimated to range from 1% up to 20% in children. Such variation is attributed to several factors including diagnostic criteria, investigative methods, the population of children, and sources of information. Many causes have been suggested, but none are universally accepted, possible due to the complexity and interaction of these factors.[4]

How lead levels may contribute to either autism or ADHD is still being investigated. In a study by Silva et al,[5] they concluded that abnormally elevated lead levels are associated with a very small, but statistically significant increase in children's behavioral problems such as inattention and hyperactivity.

This case study explores the relationship between an elevated lead level and the symptoms seen in ADHD and autism. The case involves a child with an abnormally high lead level of 42 mcg/dl and clinical diagnoses of ADHD and autism.

Case History

The patient is a 4 ½-year-old Caucasian male from a two-parent household residing in a rural Midwest community. He is the only child in the home. At 15 months of age the parents noted that the child was always "on the go." By the time he was 2 years old, the family physician noted speech-language deficits, along with hyperactivity. The child also exhibited abnormal behaviors such as "staring" episodes while watching television, being easily distracted and not recognizing dangerous situations.

A series of developmental measures (Childhood Autistic Rating Scale,[6] Receptive-Expression Language,[7] Bayley Mental Scale,[8] Vineland Adaptive Behavior Scale[9] and the Sequenced Inventory of Communication Development[10]) were administered to the child at numerous hospitals over the next year. Evaluations were concordant in the following areas: autistic behavior traits, attention deficit hyperactivity, and developmental delays especially in language.

At 3 years old, the child was hospitalized in order to evaluate his developmental delays and hyperactivity. A genetic examination for fragile x was negative. An EEG and C-T scan were both unremarkable. All blood chemistry tests were within the normal range except for an extremely high lead level of 42 mcg/dl. On physical examination it was noted that the patient had a cafe au lait spot on his right leg and an enlarged head two standard deviations above the mean. The patient's final diagnoses were ADHD, oppositional defiant disorder, and a communication disorder. Shortly thereafter the diagnosis of autism was given.

The patient was hospitalized again, one month after his initial visit, to assess his elevated blood lead level. The origin of his lead intoxication was still unknown. Lead tests at the patient's residence included paint, water, and plumbing, and all were within normal limits. Both parents had lead levels which were normal.

Prenatal/Family Background

The patient's mother smoked one pack of cigarettes a day in the first four months of pregnancy, but then ceased smoking. She denied any other drug use. The mother went into premature labor at 5 and 7 months. At 9 months she had an uneventful childbirth, and the patient was born weighing 8 lb, 2 oz. In his first 2 years of development, he had significant medical problems, such as chronic ear infections (approximately 15/year), 3 upper respiratory infections, 3 episodes of gastroenteritis, and recurring fevers.

The mother's medical history included arthritis, diabetes, and familial history of cancer, mental retardation and congenital deafness. The father has a history of alcohol abuse with no information on file regarding treatment. The father is self-employed and is the main caretaker of the family. He quit school in the ninth grade and obtained a GED. He has three children from a previous marriage, two of whom are 11-year-old fraternal twins both diagnosed with hyperactivity. One of the twins has severe asthma and has been held back two grades in school due to behavior problems and excessive absences.

Treatment

For the elevated lead level, the patient was treated with chelating agent Succimer. This treatment decreased the child's lead level and decreased reported excessive movement and repetitive behavior. However, a regression to previous symptoms occurred when the treatment was discontinued.

Eventually the patient was treated with dextroamphetamine for hyperactive behavior. An attempt was made with ritalin, but according to the parents it caused an increase in hyperactive behavior. Four months after his last hospital stay, the patient was also prescribed clonidine along with the dextroamphetamine, to help augment dextroampetamines effect in the evening. Succimer was again administered secondary to a "rebound" elevated lead level, and it eventually brought the patient's lead level down.

Currently, the patient is 5 years old and is in school. He attends an early intervention program where he receives special services. Also, two times a week a therapist comes to the parent's home and instructs them in parenting techniques.

Discussion

The effect of lead on neurological development is still unknown. In the case of autism, it is not known whether lead exposure may cause infantile autism during an infant's development.[11] In regard to ADHD, David[12] stated lead poisoning can cause hyperactivity, yet Hughes[13] suggests most children with ADHD have normal serum levels of lead.

In this case the patient had a lead level of 42 mcg/dl with no known causative agent. The

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possible interaction of the high level of lead with autism and ADHD on the patient may be seen by the changes the patient underwent while on succimer. Succimer is an orally active heavy metal chelating agent that forms stable water soluble complexes with lead and increases urinary lead output without adversely affecting essential mineral excretion.[14]

The patient underwent two treatments of this chelating agent over a period of 18 days. Behavioral changes were noted while he underwent treatment. The parents noted that the child was not as active on the medication with a regression occurring upon discontinuance. The change in activity level may be due to side effects associated with succimer (such as dehydration), but they were not noted during his treatment. Two self-stimulating behaviors which the patient exhibited prior to succimer treatment (twirling or playing with his hair, and standing with a stick held in front of him like the "Statute of Liberty" while staring at the end of the stick for an extended period of time) ceased with no return after the medication was discontinued. The change in energy level as well as the cessation of self-stimulatory behaviors is possibly secondary to the effects of succimer whose mode of action is basically unknown.

This complex case study brings up many interesting possibilities for further research in the areas of lead levels, ADHD, autism, and their treatment. The three conditions may be coincidental and have no impact on each other. However, clinicians should be aware and cautious about their coexistence. Since the psychoparmacology of ADHD and autism is still in its infant stage, the effects of medications such as succimer and other compounds should also be studied. Further documentation of older children or individuals with elevated lead level, ADHD, and autism might be the next step in developing a clinical correlation.

Acknowledgment

The authors wish to thank the Children's Miracle Network for funding.

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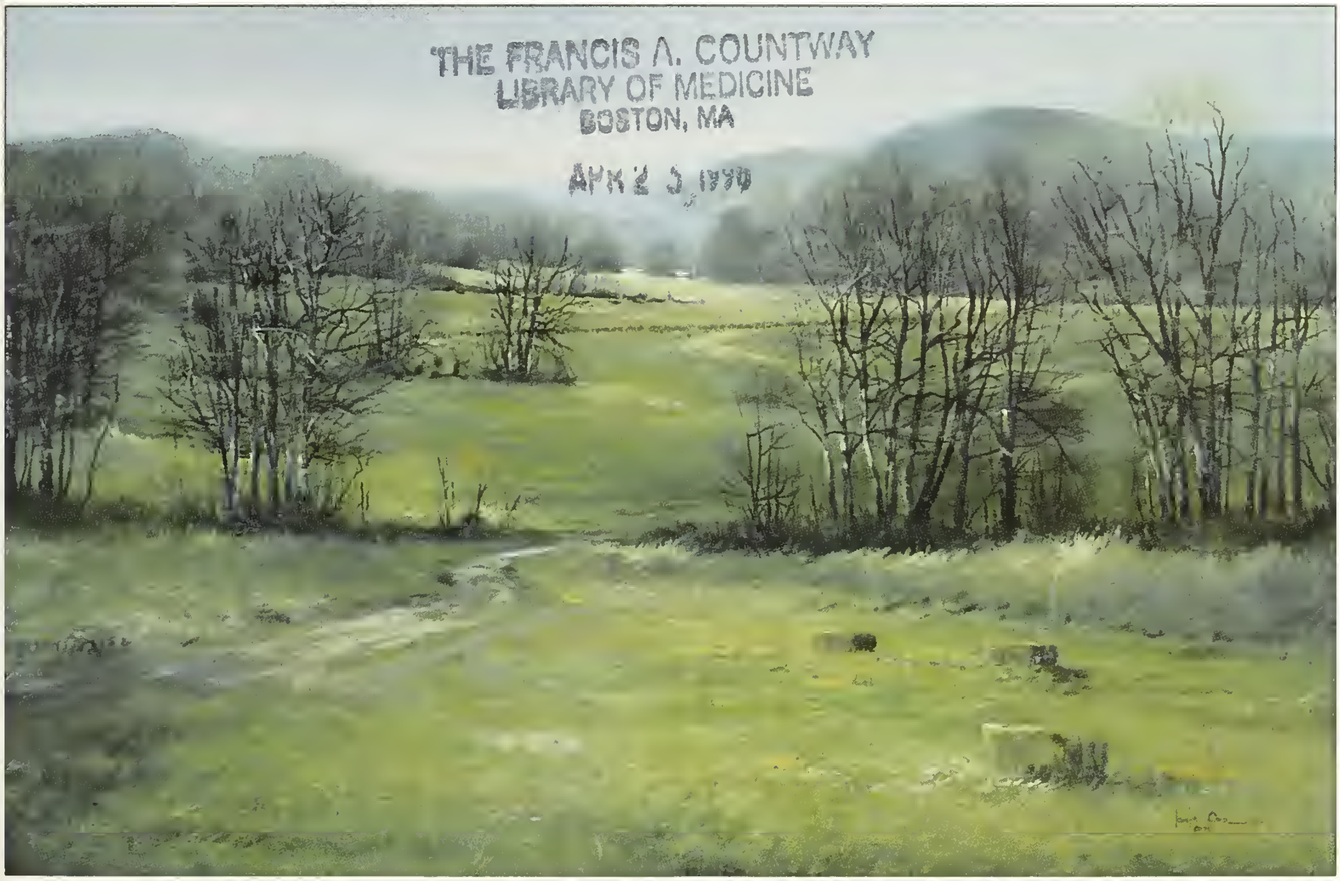

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MISSOURI MEDICINE

VOLUME 93, NUMBER 4

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On the Cover: "Morning at Mead's Flat" an 35" x 51" acrylic painting by Joseph Orr. Mr. Orr is a professional artist. His studio is located in Osage Beach, Missouri on Route KK, a ½ mile east of Tan-Tar-A Resort.

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, [ISSN 0026-6620] is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. **Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept., P.O. Box 1028, Jefferson City, MO 65102.** The subscription price per year for non-members is $60.00. Annual subscription for members is included in the annual membership dues. Single copies are $8.00 and the per copy cost of the annual August Directory is $40.00. Copyright 1996 by the Missouri State Medical Association. The opinions expressed by the authors are not necessarily those of the Missouri State Medical Association nor should publication be considered an endorsement by the MSMA. Printed by the Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

Heros and Memories

J. Regan Thomas, MD, Editor

Vince Edwards died last month. One more of my childhood memories is now just that, a memory. I'm sure Mr. Edwards must have had other acting credits in his career, but he will always be remembered as *Ben Casey, M.D.*

He played the lead character in what was then my favorite television program. The character perhaps did not really make me decide to become a doctor, but it certainly reinforced the concept and developed a strong positive image in my mind as to how a doctor should behave. That was particularly important to me as a naive farm boy without physicians in my family and only literary or dramatic figures to help mold any sense of being a physician. Sure there was Dr. Howard, a general practitioner who served as our family doctor through the years. Dr. Howard was held in great esteem in our family. He delivered my brother and sisters, completed our school and sports physicals, provided middle of the night suggestions for earaches and fevers, performed an appendectomy on my brother, sutured a variety of lacerations, and when required, made house calls. He was revered by all of us and truly appreciated, but somehow I never connected with him as a role model. Maybe he was too old (probably about the same as my age now). But *Ben Casey, M.D.* was...well, COOL.

There were of course other T.V. doctors. Dr. Kildare always seemed a bit too "square." There was even *Rex Allen, Frontier Doctor*. I loved the show but of course a wild west cowboy doctor was more for fun and not the stuff of adolescent life plans. "Doc" on *Gunsmoke* didn't even seem to have a last name (I think it was Doc Adams) and of course there was the age issue. As I got older Marcus Welby came along but for me, no one had the impact of *Ben Casey, M.D.*

Remember the melodramatic opening of the program each week? "Man, Woman, Life, Death, Infinity," were spoken by the narrator accompanied by the Greek symbol and a voice that became so familiar I can hear it now.

Ben Casey not only acted "cool," but he dressed "cool" too. The high collared white doctor's smock always was unbuttoned at the top and folded down in a nonchalant, but somehow calculated fashion. He took the sage advice of his mentor, Dr. Zorba, each week and translated the message into actions that resulted in a deeper insight for the young Casey and greater comfort for his patients. Dr. Zorba of course had that great Einstein like haircut that could in those days only be tolerated in a slightly eccentric genius or a mentor of great wisdom. Each week that equation worked, the experienced elder partner coupled with the energy and passion of the youthful associate.

Even at my young age at the time, I was struck by Ben Casey's personal interest and concern for his patients and his drive to improve their situation. Sure, I knew it was just T.V., but nevertheless, the style, the look, the character, and to Vince Edwards' credit, the acting left its mark. For a rural kid, in front of that T.V., who had the unlikely dream of becoming a doctor, Ben Casey made an indelible impression. A hero or role model, I'm sure I would not have used those terms at the time. However, now 35 or 40 years later, I still remember it. It was an image that helped to establish my own criteria for what it meant to be a doctor. It was an image that helped confirm that medicine was worthy goal.

Who are the heros today? Who today inspires our children to be doctors or teachers or simply good people and responsible citizens? Of course parents, teachers, clergy, and others in contact with our children all have a role. It would be a shame if kids didn't also have some heros from the world of literature or drama. There is discussion of utilizing technology like the "V-chip" to monitor what children see on T.V. The television networks are developing self regulation through a program rating system to allow parents to monitor program content. But these actions only act to avoid or eliminate certain programming. They do nothing to promote or ensure positive images. They provide no heros.

Television has the greatest impact on our opinions and lifestyles of any source of information or entertainment in today's society. Politicians and advertisers spend millions in recognition of this fact. So why aren't there more positive role models on T.V. for our kids? The answer is, it doesn't "sell" well.

The media should be able to be profitable. No one should expect a commercial entity to not be successful and ensure a profit. The disappointment comes when there is not a high calling to perhaps accept less profit while making sure appropriate role models are provided. I'm confident that updated positive images will in fact sell and continue profitable ventures for the T.V. industry. It will be sad for our children and grandchildren to miss Ben Caseys of their own.

I wonder if the series would stand up to scrutiny today? Would it seem too dated or maybe just too irrelevant to today's audience? Are my childhood memories enhancing the reality of how it actually was? It doesn't matter. For its time and for my time, it was terrific.

I'm sorry to learn of Mr. Edwards' death. I hope he had some idea of the enjoyment his character and his work provided. I hope he would appreciate a message from an admiring farm kid: "Thank you Dr. Casey, I'll miss you." **MoMed**

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Daniel O'Sullivan, MD
MSMA President

Daniel F. O'Sullivan, MD

Daniel F. O'Sullivan, MD, a General and Thoracic Surgeon from St. Louis, will serve as President of the Missouri State Medical Association in 1996-97. He will be installed, April 13, 1996, during MSMA's 138th Annual Convention at the Lake of the Ozarks.

Dr. O'Sullivan was born in St. Louis in 1934. He earned his medical degree in 1959 from the St. Louis University Medical School and served his internship and residency there. He was Assistant Director of St. Louis University Surgical Service at John Cochran VA Hospital from 1965 to 1966.

He served as a Captain in the U.S. Army from 1966 to 1968. He was Chief of Thoracic and Vascular Surgery at both the Martin Army Hospital at Fort Benning, Georgia, in 1967 and at the 85th Evacuation Hospital in Vietnam in 1968. He was Director of Emergency Services at Firmin Desloge Hospital from 1968 to 1970.

Dr. O'Sullivan is board certified by the American Board of Surgery and the American Board of Thoracic Surgery, and is a Fellow in the American College of Surgeons.

Dr. O'Sullivan has been on the staff at St. Anthony's Medical Center since 1965. He was Chief of Surgery and President of the Medical Staff 1989-1990. He served on the Board of Directors from 1986 to 1992. Dr. O'Sullivan has chaired and been a member of several hospital committees. He also serves the hospital staffs of St. Mary's Health Center, St. John's Mercy Medical Center, Cardinal Glennon Children's Hospital, and St. Louis University Hospital. He is an Associate Clinical Professor of Surgery at St. Louis University.

Dr. O'Sullivan has been a member of the Missouri State Medical Association since 1964 and an MSMA Councilor since 1990. He was Chair of the Council in 1994-1995. He served as an MSMA House Delegate from 1986 to 1990. He has also served on MSMA's Legislative, Tort Reform and Nominating committees. Dr. O'Sullivan has been President and Chair of Missouri State Medical Services, Inc. since 1994.

He has served the St. Louis Metropolitan Medical Society as a Councilor and as President of SLMMS in 1989. He was Chair of the Grievance and Past Presidents committees and member of the Nominating Committee.

Dr. O'Sullivan is a member of the St. Louis Surgical Society. He served as Vice President in 1993. He is a member of the American Medical Association, the American College of Surgeons, the Hanlon Surgical Society, and a founding member of the American Trauma Society.

Dr. O'Sullivan and his wife, June, have eight children and thirteen grandchildren. During his years of practice, he has served on the Missouri Athletic Club Board of Governors and as President in 1989-1990. He also served on the Board of Directors of Downtown St. Louis and on the Board of Directors of Boys Hope.

In assuming his leadership position for the Association, Dr. O'Sullivan said, "I hope to direct my energy to the restoration of the esteem, respect and professionalism with which the practice of medicine has always been associated." MoMed

Joan M. H'Doubler
MSMA Alliance President

"After many years of being active on both the county and state levels, I believe I have received far more than I have given. The bounty of emotional gratification can change your life, you are making a difference, and it is good," Joan said of her Alliance involvement.

Joan M. H'Doubler

Joan M. H'Doubler will be installed as the 1996-1997 President of the Missouri State Medical Association Alliance, April 13, 1996, during the 71st MSMAA Annual Convention at the Lake of the Ozarks.

Joan is originally from Michigan City, Indiana. She attended St. Joseph's School of Nursing in South Bend, Indiana, and became a registered nurse. She has worked in Milwaukee, Philadelphia, and Gary, Indiana, before arriving in Springfield, Missouri. In 1977 she became acting head nurse of surgical unit at Cox Medical Center North. She acquired her Bachelor of Science in Nursing from Drury College and elected President of the Alpha Sigma Lamda Honor Society.

Joan's involvement in the medical alliance began shortly after her marriage to Charles E. H'Doubler, MD, a general surgeon. Together, they joined the Greene County Medical Society Ad Hoc Historical Committee. After just over four years of work, the committee celebrated the grand opening of the Medical Museum of the Ozarks at the Cox Medical Center North.

"Doctors' Day" is one of Joan's favorite Alliance activities. She chaired Greene County's Doctors' Day events in 1984 and 1985. GCMSA organized a blood donor drive for the American Red Cross. Contributions doubled on Doctors' Day and Greene County became the first recipient of the Mary Kay McPhee silver bowl award, presented annually to the most outstanding Doctors' Day project by a county alliance.

Joan has served on the MSMA Alliance Board for the past ten years. Her first standing committee was Doctors' Day in 1987 and 1988. She then chaired International Health for the next two years.

In 1990, she was installed President of the Greene County Medical Society Auxiliary, as it was then called, and received the Pat Ash Award in 1992 for outstanding dedication to GCMSA.

Before completing her first year as county president, she accepted a partial term as MSMAA Recording Secretary. She became AMA-ERF Vice-President. Following that term, she became Membership Vice President for two years.

This past year Joan attended AMAA Leadership Confluences. She has made a strong commitment to the concept and promotion of leadership. "Where else in the world of volunteerism are leaders so well trained and motivated? I am willing and ready to work hard to make Missouri's county leaders among the finest in the nation!" Joan said.

She has served as board member in charge of fund-raising for the American Red Cross, Greater Ozark Region. She has also served two years on the board of the Missouri Chapter of the National Committee to Prevent Child Abuse and Continues to support their programs. She is currently serving her second year as Southern Medical Association Auxiliary Health Counselor, encouraging breast cancer awareness.

Joan and Charles have a combined family of six children. Three daughters, three sons, and five grandchildren. **MoMed**

Radiology Quiz #3

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by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

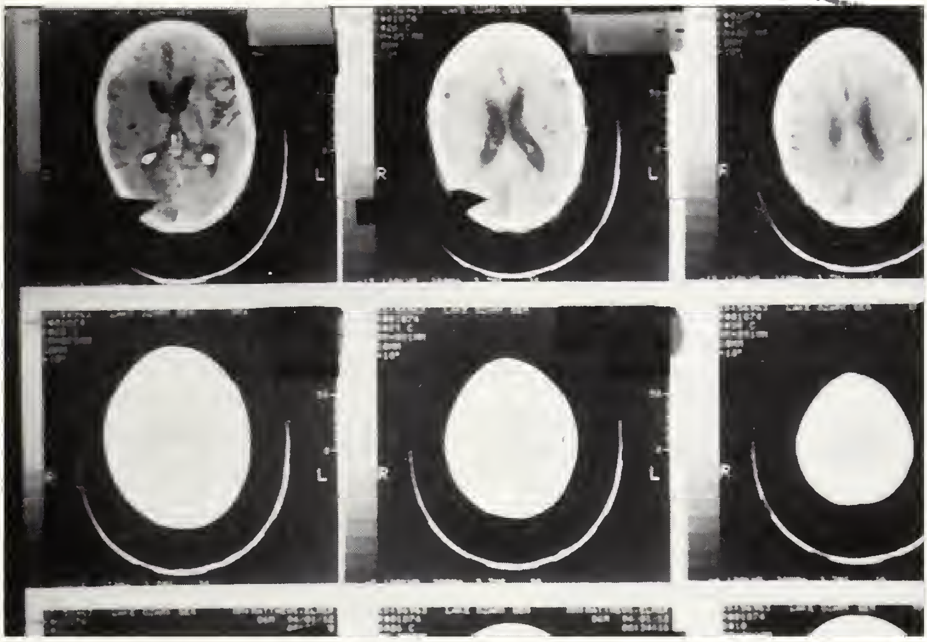

Figure 1

A 86-year-old man presented to the ophthalmology clinic with sudden onset of visual difficulty. A contrast enhanced C.T. scan of the head was performed (Fig 1), showing an apparent zone of infarction (arrows) in the right occipital lobe. Which visual field defect would be expected from the location of the infarct?

- **a. Right eye blindness**
- **b. Bitemporal hemianopsia (affecting lateral halves of both visual fields)**
- **c. Right homonomous hemianopsia (affecting right halves of both fields)**
- **d. Left homonomous hemianopsia (affecting left halves of both fields)**

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

ANSWER: d. Left homonomous hemianopsia (affecting left halves of both fields)

To determine the location of a lesion causing a visual field defect, a knowledge of visual neural pathways is essential. Visual impulses leave the retina and travel along the optic nerve. At the optic chiasm, fibers receiving signals from the medical half of each retina (temporal portion of each visual field) cross over and enter the optic tracts along with fibers from the medial half of the ipsilateral visual field. Fibers from the optic tracts enter the lateral geniculate body. From the lateral geniculate body, most fibers continue in the optic radiations, extending to the visual cortex of the occipital lobe. Fibers from the medial part of the lateral geniculate body extend to the upper part of the visual cortex (above the calcarine sulcus, and receive impulses from the lower homonomous quadrants of the visual field. Fibers from the lateral part of the lateral geniculate body extend to the quadrants of the visual field.

Because of the above described pathways, a lesion in the occipital lobe would be expected to cause a homonomous hemianopsia or homonomous quadrantanopsia of the opposite visual field. Therefore, a lesion in the right occipital cortex would cause a loss of vision in the left sides (or upper or lower quadrants) of both eyes. Option D is therefore the correct response. C.T. scanning has been used to evaluate stroke patients for about 20 years, chiefly to exclude other etiologies of symptoms, including hemorrhage or neoplasm. Magnetic Resonance Imaging (MRI) has been shown to be more sensitive than C.T. for detecting early infarction, and determining extent of cerebral infarction.

Reference

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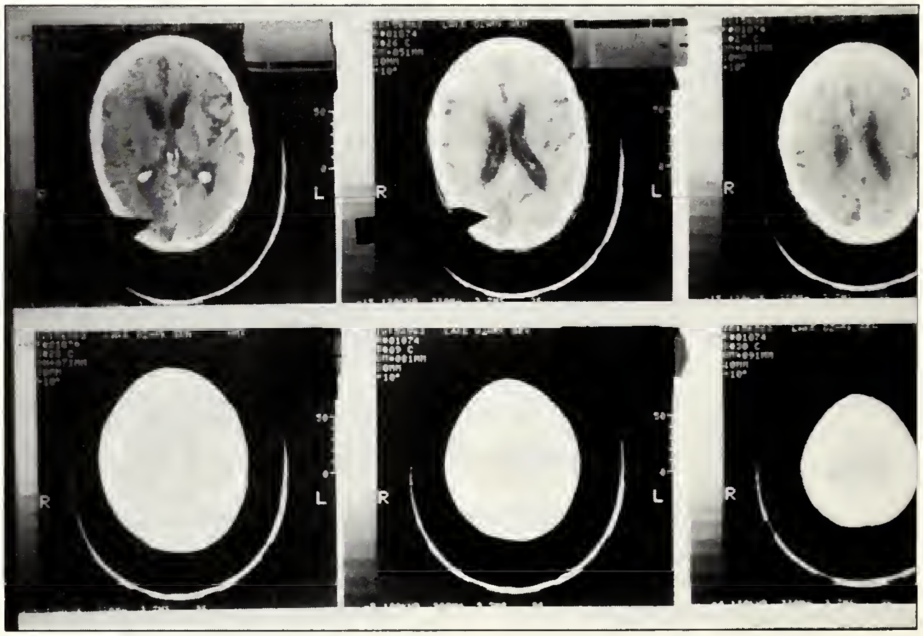

Repeat Figure 1

Membership Notes

Loretta Loftus, MD, professor of medicine and chief of hematology/oncology at the University of Missouri-Kansas City School of Medicine, is the principal investigator for a grant project from the Susan G. Komen Breast Cancer Foundation. The funding will continue a breast cancer screening and education program for patients and medical students. The program provides an organized, in-depth experience for medical students in clinical breast examination, detection of breast lumps, and knowledge of breast cancer screening guidelines. The students also learn how to instruct their patients in the techniques of breast self-examination.

Gordon C. Sauer, MD, of Kansas City, Missouri, has co-authored with Dr. John Hall the 7th edition of his *Manual of Skin Diseases* published by Lippincott-Raven. Dr. Sauer continues in medical practice and is an emeritus clinical professor of medicine in dermatology at the University of Kansas.

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine****, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

AMA PHYSICIAN'S RECOGNITION AWARDS

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

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In Memoriam

Louis F. Aitken, MD, 93, Ladue, Missouri, died January 25, 1996. Dr. Aitken received his medical degree at Washington University in 1927. He was in private practice for more than 60 years before he retired in 1988. Dr. Aitken was an assistant professor emeritus at Washington University.

Colita R. Banez, MD, 54, St. Louis, Missouri, died February 19, 1996. Dr. Banez received her medical degree at the University of Santo Thomas in Manila in 1967. Dr. Banez had been on the staff at St. Louis State Hospital since 1971. She worked in the hospital's forensic division. Dr. Banez was a lieutenant colonel in the Army Reserves and served in Operation Desert Storm.

Hjalmar E. Carlson, MD, 90, Overland Park, Kansas, died February 5, 1996. Dr. Carlson received his medical degree at the University of Minnesota in 1930. He served his residency at the Bell Memorial Hospital in Kansas City, Kansas, now known as the University of Kansas Medical Center. He served in the Army Medical Corps as a Captain during World War II. Dr. Carlson was a urologist in private practice in Kansas City for 50 years. He was an Emeritus Professor of Urology at the University of Missouri-Kansas City. He was Chief of Urology at Children's Mercy Hospital from 1946 to 1966. He was Urologic Surgeon to the Federal Penitentiary in Leavenworth, Kansas, from 1940 to 1968. Dr. Carlson developed many urological devices, and was the author of numerous research, clinical and scientific articles. He was the Founding Editor of the Urologist's Letter Club. He authored several books. Dr. Carlson was past president of the South Central section of the American Urological Association; past president and founding member of the Society of Pediatric Urology, and the Urological Section of the Southern Medical Association; Past president of the staff at Children's Mercy Hospital and Trinity Lutheran Hospital; an honorary staff member of Children's Mercy Hospital, Trinity Lutheran Hospital and St. Luke's Hospital. He was a Fellow of the American College of Surgeons, and a Fellow of the American Academy of Pediatrics; a member of Sigma XI; the Association of Military Surgeons; the American Medical Association and the New York Academy of Medicine.

Raymond C. Conrad, MD, 86, Springfield, Missouri, died January 20, 1996. Dr. Conrad received his bachelor's degree at the University of Missouri-Columbia and his medical degree at Washington University in 1935. He did post graduate work at the University of Kansas and Harvard Medical School. Dr. Conrad practiced medicine in Portageville, Missouri, for 10 years and in 1945 moved to Springfield where he was an obstetrician and gynecologist until his retirement in 1980. Dr. Conrad was a member of the Greene County Medical Society, Missouri State Medical Association and American Medical Association. He was appointed to serve on the Missouri State Board of Registration for the Healing Arts. In 1945 he received a presidential award for service to his country.

Arthur R. Dalton, MD, 80, Town and Country, Missouri, died January 24, 1996. Dr. Dalton received his bachelor's degree at the University of Missouri-Columbia in 1938 and his medical degree from Northwestern University School of Medicine in Chicago in 1941. He served as a flight surgeon in World War II. Dr. Dalton was chief of surgery at Deaconess Hospital from 1958 to 1963 and again from 1981 to 1986. In 1958, he was appointed to the hospital's first medical administrative committee, which set standards for the medical staff. He also taught surgery in the Deaconess training program and had been on staff at Missouri Baptist Hospital. He retired in 1989. Dr. Dalton was a member of the American College of Surgeons.

Richard K. Danis, MD, 62, Ladue, Missouri, died January 30, 1996. Dr. Danis received his medical degree at St. Louis University in 1957. From 1958 to 1960, he served as a surgeon in the Navy. Dr. Danis practiced at Cardinal Glennon from 1965 until he retired in 1994. He was past president of the Child Center of Our Lady of the St. Louis University School of Medicine Alumni. He was active in several local charities, including Catholic

Charities. Dr. Danis was a member of the American Academy of Pediatrics and the American College of Surgeons.

Luke J. Dlabal, Sr., MD, Independence, Missouri, died February 25, 1996. Dr. Dlabal received his medical degree at the University of Kansas in 1938. He completed his internship at St. Joseph's Hospital. Dr. Dlabal practiced medicine in Independence, Missouri, for 47 years, before retiring in 1986. He was a member of the American Academy of Family Physicians, the Metropolitan Medical Society of Greater Kansas City, the Missouri State Medical Association, and the American Medical Association. Dr. Dlabal served as a Major in the Army Medical Corps during World War II. He served as president of the medical staff at the Independence Sanitarium and Hospital. He was also a member of the American Academy of Ophthalmology and Otolaryngology.

Jackson K. Eto, MD, 78, Clayton, Missouri, died January 24, 1996. Dr. Eto received his medical degree at St. Louis University in 1942. He had taught and was a former chair of pediatrics at St. Mary's Hospital, now St. Mary's Health Center in Richmond Heights. Dr. Eto was a former head of pediatrics at DePaul Hospital, now DePaul Health Center in Bridgeton. He was the first elected president of the Cardinal Glennon Children's Hospital medical staff. Dr. Eto was a member of the American Academy of Pediatrics.

Frederick W. Hink, MD, 91, Independence, Missouri, died February 8, 1996. Dr. Hink attended the University of Missouri School of Medicine, Columbia, receiving his bachelor of science degree in 1928. He then transferred to the Kansas University School of Medicine and received his medical degree in 1930. He completed an internship at City Hospital in St. Louis, then returned to his home area of Sugar Creek and Independence to begin his medical practice. He maintained a general family practice for 53 years, retiring in 1983, at age 79. Dr. Hink was on the staff of the Independence Sanitarium and Hospital for 48 years. He delivered over 2,000 babies in his practice with many being second and third generation. He conducted his practice as a "country doctor" with house calls and walk-in office. Dr. Hink was a member of the American Academy of Family Physicians and the American Medical Association.

Alex H. Kaplan, MD, 83, St. Louis, Missouri, died February 19, 1996. Dr. Kaplan received his medical degree at St. Louis University in 1936. He interrupted his studies at New York Psychoanalytic Institute to serve as a lieutenant in the Navy during World War II. In 1950, he completed his training at the Chicago Psychoanalytic Institute. From 1955 to 1977, he was a professor in clinical psychiatry at the Washington University School of Medicine. In the mid-1950s, he was acting director of the university's Community Child Guidance Clinic. He was also a lecturer in social psychiatry for 26 years at the university's School of Social Work. Dr. Kaplan helped set up the St. Louis Psychoanalytic Foundation, of which he was a former medical director. He was associate medical director of the St. Louis Psychoanalytic Institute. Dr. Kaplan was a past treasurer, president-elect and president of the American Psychoanalytic Association; a past president of the Eastern Missouri Psychiatric Society; and a former treasurer, first vice president, president-elect and president of the American College of Psychoanalysts. He wrote many articles about psychoanalysis for medical publications.

Maxwell Rachlin, MD, 77, Ellington, Connecticut, formerly of Ladue, died February 27, 1996. Dr. Rachlin received his medical degree at the University of Toronto in 1942. He served as a physician in the Canadian Army in the mid-1940s and moved to St. Louis in 1948. Dr. Rachlin was in private practice for more than 35 years in St. Louis. He was formerly on the staffs of Jewish and Barnes hospitals. He retired in the early 1980s and moved to Connecticut about 10 years later. Dr. Rachlin was a founding partner of the Opthalmological Center in Clayton and a past president of the St. Louis Opthalmological Society. He was a member of the American Academy of Ophthalmology and Otolaryngology and the American Physicians Fellowship, Inc.

Continued on page 160

New Members

Boone

Walter B. Greene, MD - PD
M562 Health Sciences Ctr.
Columbia, MO 65212
Univ of North Carolina; 1972

Cape Girardeau Co. Area

Richard E. Draper, DO - EM
1701 Lacey Emerg Dept.
Cape Girardeau, MO 63701
Univ Hlth Sci Ctr Osteo Med KC; 1981

William S. Lewis, MD - EM
1701 Lacey Emerg Dept.
Cape Girardeau, MO 63701
Univ of Arkansas Little Rock; 1992

Richard N. Mitchell, DO - EM
1701 Lacey Emerg Dept.
Cape Girardeau, MO 63701
Univ of Osteo Med, Des Moines, IA; 1989

Kee B. Park, MD - NS
3129 Blattner Dr., Cape Girardeau, MO 63701
Robert Wood Johnson NJ; 1989

Chariton-Macon-Monroe-Randolph

Owen L. Woodward, DO - FP
Box 337, 101 S. Atterbery St.
Atlanta, MO 63530
Kirksville Osteo College; 1951

SEMO

M. A. Danish Rizvi, MD - FP
1012 N. Main St., Sikeston, MO 63801
Dow Medical Col Karachi, Pakistan; 1989

Residents

Omar Jaraki, MD - CD
Pairote Jaroonwanichkul, MD - ON

Students

Washington University

Teresa Chapman
Charles A. Harris
Allen B. Kachalia

IN MEMORIAM - Continued from page 159

J. Ned Smith, MD, 70, Columbia, Missouri, died February 18, 1996. Dr. Smith completed premedical studies in the Navy V-12 program at De Pauw in Greencastle, Indiana. He received his medical degree at the University of Iowa in 1949. Dr. Smith interned at St. Luke's Hospital in Chicago, and did a residency in internal medicine at the University of Iowa. He finished his sub-specialty training in gastroenterology at the Ford Hospital in Detroit. During the Korean War, he served two years in the Navy on the U.S. hospital ship, the Repose. Dr. Smith was the author of the textbook, *The Essentials of Gastroenterology*. He joined the staff of the University of Missouri-Columbia School of Medicine in 1956 at the opening of the University Hospital and Clinics. He retired as an emeritus professor in 1989. During his tenure he also served on the staff at the University Student Health Service and the Harry S. Truman Veterans Hospital. He was a member of the Boone County Medical Society, the American Medical Association, the American Gastroenterology Association, the American Society for Gastrointestinal Endoscopy, the Lahey and Ford Hospital Alumni Associations, the Sigma Zi scientific society and Sigma Nu medical fraternity.

Joe A. Zimmerman, MD, 74, Kennett, Missouri, died December 26, 1995. Dr. Zimmerman received his medical degree at the George Washington School of Medicine in 1946. He interned at Gallanger General Hospital in Washington, D.C. Dr. Zimmerman served in the U.S. Army where he achieved the rank of Captain. He practiced medicine as a general practitioner for 40 years in Kennett, Missouri. Dr. Zimmerman practiced at Presnell Hospital, then Dunklin County Memorial, which became Twin Rivers Regional Medical Center. He retired in 1991. Dr. Zimmerman served as an honorary colonel for Governor John M. Dalton from 1960 to 1964. He also served as honorary colonel for Governor Warren E. Hearns from 1964 to 1972. He was on the Missouri State Metal Health Council from 1961 to 1963 and on the board of directors for three years. Dr. Zimmerman was on the Governor's Advisory Council for mental retardation and other developmental disabilities, both as a member and later as chair. He was appointed to the advisory committee for the University of Missouri Health Sciences by board curator, William H. Billings. Dr. Zimmerman served as Chief of Staff at Dunklin County Memorial Hospital. He was a Fellow of the American Academy of Family Physicians.

Kansas City Doctors and Lawyers Agree on an Interprofessional Code

Elizabeth Dixon Badger, JD and R. Christopher Abele, JD

The Metropolitan Medical Society of Greater Kansas City and the Kansas City Metropolitan Bar Association recently adopted a jointly-revised version of the Interprofessional Code. The Interprofessional Code is intended to provide guidance on matters where medical and legal professionals frequently interact. Topics addressed in the Code include requests for medical records, medical reports, conferences between physicians and attorneys, the physician fact witness, the physician expert witness, depositions, subpoenas, testifying in court, professional fees, and the physician/attorney complaint procedure. The Code also includes some helpful forms which are consistent with the Code and which may be used in medical offices. This article is designed to highlight the general Code topics as well as significant changes made in this revision of the Code.

Requests for Medical Records

Most physicians regularly encounter patient-authorized requests for medical records and have instituted front office procedures for responding to them. The Code reinforces the Missouri statute that dictates prompt compliance with these requests.[1] Physicians are encouraged to respond in writing to these records requests, and sample responses are contained in the Code's Appendix.

Failure to promptly comply with a properly-authorized, written request for records can subject the physician to civil liability.[2] Conversely, the Code instructs that turning over medical records when there is no signed authorization or legal waiver of the physician's duty of confidentiality can also subject the physician to civil liability. An exception to the requirement to provide records can arise if the physician believes the patient's condition will be adversely affected should the patient gain access to his or her own records.[3]

The medical authorizations must be read closely to determine what records the physician should release. The Missouri Supreme Court recently has held that defendants cannot require plaintiffs to sign broad and unlimited authorizations.[4] As a result, physicians will be receiving more authorizations which, instead of allowing release of all of the patient's records, only authorize release of records within specific time frames or which only authorize release of records pertaining to specific physical issues. When responding to these limited authorizations, remember the Code's instructions that civil liability can result from turning over medical records beyond those authorized by the patient.

A recent Missouri statute limits the charges a physician may make for providing copies of medical records in response to these requests. The authorized charges include a handling fee of not more than $15 plus a copying fee of not more than 35 cents per page.[5] Additionally, reasonable charges may be made for records that are not readily photocopied, such as x-rays. There is not a similar statute in Kansas. However, the Kansas Court of Appeals explored this issue in a recent

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case and noted with approval an agreement between a local bar association and a medical society to limit these charges to a $15 administrative fee plus 20 cents or 25 cents per page for copying.[6]

In the recent Interprofessional Code revision, an area of confusion and some debate between the professions developed over the scope of an authorization and the proper response. In particular, the view was expressed that a physician should provide in response to a records request only those portions of the patient's file originally generated by the physician responding to the request. The drafters of the Code concluded:

> If the patient's signed authorization specifically refers to disclosure of all records, "including correspondence or reports from other physicians," the correspondence should be released, unless it bears a restrictive label prohibiting re-distribution (e.g., as with HIV or drug treatment records). [Remember that the privilege is held by the patient and not the physician.] However, some authorizations do not make any mention of correspondence or reports received from other health care providers. The authors of this Code note that, until Missouri law is clarified on this point, a physician in this latter situation could either: (1) request that a more specific authorization be sent with this language in it before he or she releases such correspondence; (2) release copies of all patient records kept in the ordinary course of business, including reports or correspondence sent to him or her by other providers, except those records that bear a restrictive label prohibiting re-distribution (e.g., as appears on drug/alcohol or HIV records); or (3) release his or her own records, but inform the requester that there are other doctors' records in his or her chart not released, identifying those health care providers so that a separate request could be sent to them. These options are not offered as legal advice, nor is it assured that any of these three courses of action would go unchallenged. All three courses avoid unilateral action by a physician to secretly withhold records, which is the kink of action likely to result in legal trouble for the physician.

Medical Reports

As with a request for medical records, a request for a medical report must be authorized by the patient. In contrast to a records request, however, a physician may choose not to provide a report. The Code correctly notes that such reports can resolve some medical/legal disputes short of litigation, and that if a physician does not provide a report, the physician may be subpoenaed to provide deposition testimony.

The Code provides guidance to physicians and attorneys as to the kinds of information on which a report may be requested. The Code suggests that the parties agree in advance as to the amount of any fees or expenses for generating the report.

Conference Between Physicians and Lawyers

Until the decision in *Brandt v. Medical Defense Associates*,[7] there was both confusion and debate regarding the propriety of meetings between attending physicians and attorneys who represent interests adverse to the patient. While the debate continues as to the utility of such meetings, the Supreme Court provided some guidance in the *Brandt* case. The Code is consistent with *Brandt* and notes that when a patient files a lawsuit that alleges personal injury, or when a patient signs an authorization to release information regarding his or her physical condition, the patient has waived the privilege of confidentiality to that extent and cannot prohibit discussions between the attending physician and attorneys for the adverse parties.

However, the physician may want to refuse to participate in such discussions because, under the *Brandt* decision, the ultimate risk of liability for disclosure of confidential information falls squarely on the physician. The physician will be subject to civil liability to the patient if he or she reveals confidential information beyond the scope of the waiver, regardless of whether the waiver is by authorization or by filing suit. The Code notes that physicians who decline to participate in such meetings may be required to provide the information at court or in a deposition through the use of a subpoena. For those physicians who are willing to participate in meetings, the Code suggests ways to attempt to assure that the subjects discussed during such meetings are proper.

The Physician as a Fact Witness and Expert Witness

While many physician are reluctant witnesses in legal cases, the Code correctly points out that the two professions often must cooperate in order to resolve their patient/client's personal concerns and needs. The Code suggests ways that physicians and attorneys can facilitate cooperation and notes that the AMA/ABA Policy Compendium provides that "it is always improper and unnecessary for the attorney to embarrass or harass the physician."[8]

With a reminder that attorneys are advocates and that the physician's role while serving as an expert witness is not that of an advocate, the Code states that "[a]ny physician who accepts the responsibility for providing expert testimony is performing a legitimate professional service when he or she testifies honestly."[9]

Subpoenas/Depositions/ Testifying in Court

Subpoenas are orders which can compel a physician to testify at a deposition or at trial. Refusal or failure to obey a subpoena may subject the physician to contempt of court, a fine, imprisonment or both. However, the Code reminds physicians that they are entitled to challenge a subpoena if it is unreasonable or oppressive. In Missouri, this requires an affirmative legal act by the physician in advance of the date and time the subpoena requires compliance. The Code also provides some guidance as to other steps a physician may take short of a direct legal challenge to the subpoena.

The Code notes that Missouri law and practice provide that a physician be paid a "reasonable hourly fee" for time spent in depositions and is entitled to expect reasonable payment for time spent in court as well. The Code reminds physicians and lawyers that disputes are minimized when there is a clear understanding of those fees and who is responsible for them in advance. The AMA/ABA Statement on Interprofessional Relations states, "When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient."[10]

Physician-Attorney Compliant Procedure

One of the purposes of the Code is to provide guidance to the legal and medical professions to avoid disputes in medical/legal matters. Nevertheless, there is an informal mediation procedure to resolve disputes short of litigation which may arise between members of the Metropolitan Medical Society of Greater Kansas City and the Kansas City Metropolitan Bar Association.

While the Interprofessional Code does not have the force of law, it represents careful thought and consideration by both professions. The lawyers who participated in this process worked to make the Code consistent with Missouri law. The physicians who devoted their time and talents brought important practical perspective to the process. The result is a document which should provide guidance to both professions. MoMed

References

1. Mo. Stat. Rev. § 191.227.1 (1994), which requires that copies of medical records be furnished "within a reasonable time of the receipt of the request."
2. *Wear v. Walker*, 800 S.W.2d 99 (Mo. Ct. App. 1990).
3. Mo. Stat. Rev. § 191.227.1 (1994).
4. *State ex rel Stecher v. Dowd*, Case No. 77802 (Mo. banc 1995).
5. Mo. Stat. Rev. § 191.227.1 (1994).
6. *Bethany Medical Ctr. v. Wallace, Saunders, Austin, Brown and Enochs, Chartered*, 880 P.2d 1289, 1290 (Kan. App. 1994).
7. 856 S.W.2d 677 (Mo. banc 1993).
8. AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys, AMA Policy Compendium, Section 265.997(c) (1994).
9. Interprofessional Code Governing Relations between Physicians and Attorneys, pg. 8 (1996).
10. AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys, at Section (7) (1994).

The Authors

Elizabeth Dixon Badger, JD and **R. Christopher Abele, JD,** are members of the Kansas City Metropolitan Bar Association and are in private practice in Kansas City, Missouri. Both have substantial experience representing health care providers. Ms. Badger and Mr. Abele are partners in Badger & Levings, L.C., Kansas City, Missouri.

AMA Study of the Federation

Robert Phillips, MD

"We, in The House of Medicine, have urgent need of mustering around our central purpose, that being the health of the citizens of the State of Missouri."
– ***Dr. Frederick Hahn***

I was struck by Dr. Hahn's commentary in November, 1995 issue of *Missouri Medicine*. His recounting of the many ways in which the House of Medicine stands divided struck a chord within me and captured a pervasive feeling within the Federation. This concern and its recognized implications for our profession and our patients was the impetus for "The Study of the Federation" which presented its initial report last October. At the AMA Interim Meeting in December, the report's fundamental premises as well as some specific recommendations were accepted on how the new Federation should work. The House of Delegates sent back specific aspects of the report for further work, among which were the formulas for specialty representation and providing representation for practice and demographic characteristics. A clearer picture of implementation was also requested.

Since December the Project Team has queried the entire Federation and received input from over 50 organizations and individuals from state, county, and specialty societies regarding its follow-up report. We used these to more specifically answer the questions put to us in December and the report is now out for discussion. If this second set of recommendations is approved in June, members can expect to receive a ballot with their membership material this Fall asking them to select a specialty organization to represent them in the House of Delegates.

For those wanting more background, the "Study of the Federation" was initiated by the AMA but was conducted by a 200-member Consortium and a 30-member Project Team, both broadly representative of all facets of the Federation, meaning local, state, specialty, and special-interest organizations. The study was designed to provide recommendations on how the individual components within the Federation could be better focused and orchestrated to create a more effective and unified House of Medicine.

This study has historical precedence. In 1901, the McCormack Committee proposed a revolutionary change in the way the AMA was organized so that it could become a Federation. At that time the House of Medicine was fairly homogeneous. The population of physicians was mostly born and trained in the U.S. They were either general practice or surgery and nearly all were in solo practice. Also, most health-related regulation was undertaken by state or local governments. A Federation built around state and local medical societies was a natural fit for those times.

Dr. Hahn outlined well the divisions that have developed within the House of Medicine since 1901. As a result the AMA is rapidly losing its ability to be the Federation in its current design and other organizations, including specialty organizations, have tried to meet physicians' needs. This has led to a fractured voice for the profession, increased overall dues costs, and overlapping functions and services.

In 1994-95, the Consortium and Project Team tested physicians' perceptions and found that physicians need and want help now. They perceive an environment that is forcing them to change their professional lives rapidly and they do not have a Federation to turn to for explanations of those changes or to voice their concerns about its affect on the quality of care. The House of Medicine is too fragmented. Physicians are looking for cost effective organizations that deliver real value. They want to see a Federation that is sensitive to those needs, that is unified in its message about patient care issues, that has two-way communication with them, that responds rapidly, that is cost effective, and that can demonstrate responsiveness to them, right now!

We have a real opportunity to break down the divisions in the House of Medicine. In the recommendations of "The Study of the Federation" we have means to streamline the roles of many physician-member organizations that function with and within the AMA to form a true Federation.

At the Interim Meeting, a majority of the discussion focused on the issue of governance and representation and on how specialty organizations would provide quid pro quo for an increased stake in the AMA House of Delegates. This discussion is important, but if it becomes a sticking point, it threatens the overall reformation of the Federation. I may be but a neophyte in this profession, but I recognize that if physicians do not pull together in this new competitive environment we will surely be pulled apart. The pain of such a failure will not only be felt acutely by our profession but even more so by our patients.

I would encourage members to talk to their state delegation to the AMA as well as their specialty societies about this report so that the debate in June is lively and productive. We need your input so that this reformation generates a Federation which can effectively respond to and represent you. I share Dr. Hahn's concerns about the divisions in the current House of Medicine and have faith that we can create a new Federation which will muster around our central purpose – the health of the citizens of this state and our nation. MoMed

Robert Phillips, MD, is an intern in Family and Community Medicine at the University of Missouri-Columbia School of Medicine. He is immediate past chair of the American Medical Association Student Section and currently is a member of the Federation Study Project Team.

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Analyzing Practice Costs Utilizing Relative Value Units (RVUs)

Gary M. White, CPA, MBA

"As Medicare pays based upon Relative Value Units and many managed care plans are transitioning their payment systems to an RVU-based system, it should be a long-term goal of the practice to eventually have the practice cost per RVU be at or below the Medicare conversion factor. "

As mentioned in the March article, "Preparing a Per-Member-Per-Month Capitated Bid to a Managed Care Plan," it is important to know your practice's cost per RVU to ensure any per-member-per-month capitated plan bid by your practice is not below your cost. Just as important, you should have the ability within your practice to monitor both the cost and profitability of each major cost center, such as Laboratory or Radiology, along with various site locations, if applicable.

Needing a Practice Plan

Although I am sharing with you specific analytical techniques necessary in today's practice management, I wish to regress momentarily to share with you the framework within which these applications should operate. First, all practices should have a practice strategic/business plan. This does not have to be a "thesis" but can be merely a five- to six-page outline, with each page listing a major area of emphasis with then action steps outlined with individuals responsible, due dates, and resources required. The practice plan should be a result of review and analysis of health care trends impacting your practice. Trends many of us are following currently include:

- reduction of physician panels;
- reduction of third-party fee schedules to Medicare levels;
- transition of capitation;
- Medicare transition to HMO plans, etc.

With the understanding of these and other trends, the practice then can define the major areas of emphasis in their practice plan. These may include:

- relationships/affiliations with other providers;
- relationships with managed care plans;
- improving practice efficiency and effectiveness;
- marketing the practice to insurance plans, major employers, and the community;
- developing clinical outcomes and quality measurements, etc.

Every practice should have at least a rudimentary practice plan which should be reviewed at least monthly as to progress toward specific identified objectives, revisions or updates, as necessary, as a result of changing circumstances.

RVU Spreadsheet Layout

In order to analyze your practice costs utilizing Relative Value Units, you will need to have access to a commercial spreadsheet program and a personal computer. Your practice's charge master should be set up on the spreadsheet in the format identified in the schedule headed "RVUs by Month." The columns should read: CPT-4, Description, and RVU. The schedule continues with the frequency for the current month from your monthly production report. The RVU times the

RVUs by Month

	A	B	C	D	E	F	G	H	I	J	K
1				Jan.	Total	Feb.	Total	March	Total	YTD	YTD
2	CPT	Description	RVU	Freq.	RVUs	Freq.	RVUs	Freq.	RVUs	Freq.	Total RVUs
3					(E=CxD)		(G=C+F)			(J=D+F)	(K=E+G)
4	99232	Hopital care-expanded	1.37	170	232.90	166	230.16		0.00	338	463.06
5	99233	Hopital care-detailed	1.90	9	17.10	7	13.30		0.00	16	30.40
6	99238	Discharge day manageme	1.61	55	88.55	46	74.06		0.00	101	162.61
7	99241	Consultation-focused	1.26		0.00		0.00		0.00	0	0.00
8	99242	Consultation-expanded	1.97	6	11.82	9	17.73		0.00	15	29.55
9	99243	Consultation-detailed	2.54	37	93.98	50	127.00		0.00	87	220.98
10	99244	Consultation-comp mod	3.57	16	57.12	17	60.69		0.00	33	117.81
11	99245	Consultation-comp high	4.81	2	9.62		0.00		0.00	2	9.62
12	99251	Initial consult-focused	1.29		0.00		0.00		0.00	0	0.00
13	99252	Initial consult-expanded	1.98	7	13.86	6	11.88		0.00	13	25.74
14	99253	Initial consult-detailed	2.61	97	253.17	76	198.36		0.00	173	451.53
15	99254	Initial consult-comp mod	3.58	17	60.86	15	53.70		0.00	32	114.56
16	99255	Initial consult-comp	4.85	1	4.85	1	4.85		0.00	2	9.7
17	99261	Follow-up consult-focused	0.72		0.00		0.00		0.00	0	0.00
18	99282	ER-expanded	0.88	1	0.88	2	1.76		0.00	3	2.64
19	99283	ER-detailed	1.60	1	1.60	3	4.80		0.00	4	6.40
20	99284	ER-comprehensive mod	2.44		0.00		0.00		0.00	0	0.00
21	99285	ER-comprehensive high	3.84		0.00		0.00		0.00	0	0.00
22	99291	ICU - 1 hour	5.18	2	10.36		0.00		0.00	2	10.36
23	99292	ICU per addl 30 min	2.51		0.00		0.00		0.00	0	0.00
24	99311	Nursing facility-focused	0.91	4	3.64	2	1.82		0.00	6	5.46
25	99312	Nursing facility-expanded	1.33	1	1.33	4	5.32		0.00	5	6.65
26	99313	Nursing facility-detailed	1.69		0.00		0.00		0.00	0	0.00
27	J0110	Dobutamine 250 mg in 20	0.00	1	0.00	1	0.00		0.00	2	0.00
28	J0151	Adenocard 6mg (adenosine)	0.00		0.00		0.00		0.00	0	0.00
29	J0460	Atropine sulfate inj	0.00		0.00	3	0.00		0.00	3	0.00
30	J1245	Inj Persantine	0.00		0.00		0.00		0.00	0	0.00
31	J3490	Misc inj	0.00		0.00	2	0.00		0.00	2	0.00
32	J7050	NS 500 ml	0.00		0.00		0.00		0.00	0	0.00
33	J7060	D5W 250 ml	0.00	1	0.00	4	0.00		0.00	5	0.00
34											
35	Subtotal P.5				861.64		805.43		0.00		1667.07
36											
37	**Grand Total - 5 pages**				**6196.19**		**6073.59**				**12269.78**

Note: In the example above the first four pages are not shown.

"January Frequency" column will result in the total RVUs for the month. The illustrated schedule is set up in a three-month format. Each month you enter the practice frequency for each CPT-4 code. The spreadsheet should be set up to multiply that month's frequency times the RVU to get the total RVUs for the month. The "Year-To-Date Total RVU" column on the far right has the cells defined to automatically add up the RVUs for each month in the quarter. To continue this process for the second, third, and fourth quarters, you merely move the schedule and retitle it to read April, May, and June for the second quarter; July, August, September for the third quarter; etc. The only data moved to each new schedule are the CPT-4 codes, descriptions, and RVU. You have the option of then reviewing your practice costs per RVU as often as you like. It may be most appropriate to review your practice costs per Relative Value Unit on a quarterly basis.

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Cost/RVU Analysis

	A	B	C	D	E	F	G
1		12 Mo. Ending 12/31/94		12 Mo. Ending 12/31/95			
2						Per RVU	$
3			Cost RVU		Cost RVU	%Change	% Change
4							
5	RVU (A)	58.827	64.349			9%	NA
6							
7	Practice Costs						
8	Business Exp.	$1,242,704	$21.12	$1,270.791	$19.75	7%	<2%>
9							
10	Prof. Salary	$1,698,340	$28.87	$1,592,164	$24.74	17%	7%
11							
12	Retirement	$195,898	$3.33	148,760	2.31	44%	32%
13							
14	Med/Dental/Disability	$116,134	$1.97	125,301	1.95	1%	<7%>
15							
16	**Subtotal**	**$2,010,372**	**$34.17**	**$1,866,225**	**$29.00**	**18%**	**8%**
17							
18	**Total Cost (B)**	**$3,253,076**	**$55.30**	**$3,137,016**	**$48.75**	**13%**	**4%**
19		**(A ÷ B)**					
20							
21	Medicare RVU Conversion						
22	Factor				$35.42		
23							
24	Difference				$13.33		
25							
26	**Cost Difference**						
27	**($13.33 X 64,349 RVU)**				**$857,772**		
28							
29	**As % of Total cost**						
30	**(857,772 ÷ 3,137,016)**				27%		

Continued from page 167

Chart of Account Design

To maximize the usefulness of your internal practice financial data, you should set up your accounting system to have separate departments or cost centers for each of our major activities to be able to record practice salaries and other costs to the appropriate department. Also, your charge master and "practice analysis" revenue report should be set up with CPT-4 codes grouped and subtotaled to record revenue on a departmental basis. Ideally, your computer system should be able to report monthly your entire revenue/charge analysis by CPT-4 code and Relative Value Units generated by the practice. In many cases, however, the computer systems do not yet have this sophistication and the spreadsheet approach covered here is necessary. Again, if possible, the CPT-4 codes for each area should be grouped and subtotaled separately, in addition to the grand total of all the practice Relative Value Units. For many primary care practices, the Laboratory and Radiology sections, if present, are ideally suited for this type of breakout. In our cardiology practice, we also look at such areas as echo, nuclear, exercise stress testing and office visits.

Integration of Financial and RVU Data

The monthly or year-to-date practice financial statement is then utilized to obtain the practice cost per RVU (by department or cost center, if possible) by dividing the departmental (or total) costs by the departmental (or total) RVUs.

Cost/RVU Analysis Chart

As Medicare pays based upon Relative Value Units and many managed care plans are transitioning their payment systems to an RVU-based system, it should be a long-term goal of the practice to eventually have the practice cost per RVU be at or below the Medicare conversion factor. For purposes of the cost/RVU analysis chart, I have used the proposed single Medicare conversion factor, which was being discussed this winter, of $35.42. In this case, this schedule highlights that while the practice has shown improvements in reducing its cost per RVU, it remains 27% above the Medicare conversion factor per RVU. This indicates the practice continues to need to plan for further improvements in productivity, such as: (a) continued practice volume growth, (b) improvements in physician productivity, and (c) reductions in the practice's business expenses. Do not be alarmed if your practice costs per RVU are currently significantly above the Medicare conversion factor. I believe most practices have a cost per RVU in the range of 50% above the Medicare conversion factor. By indentifying your practice's cost per RVU, you can initiate a process of internal analysis to identify and develop action plans to improve your practice's efficiency and/or productivity.

By having monthly, quarterly, and year-to-date Relative Value Unit analysis by department/cost center for your practice, you can match the practice charges and RVUs (work output) for each department's expenses to review and improve profitability and/or productivity to improve your practice's competitiveness in this dynamic and ever changing health care market.

The Author

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Physician Integration Revisited: Organizational Design and Development Under Managed Care

DECISION-MAKING IN GROUP PRACTICES

Tom Bennett, MDiv, MSW, MBA, GCG and Richard Clark, MBA

> "It takes courage to admit that you have been doing something wrong, to admit that you have something to learn, that there is a better way."
>
> – *W. Edwards Deming*

The current focus in health care is to reduce cost while maintaining and/or enhancing quality and outcomes. Payers are demanding more and better services for less cost; providers are scrambling to meet these expectations. To survive and prosper, physicians must understand and accept that this rapidly evolving environment mandates new methods of organizing the delivery of physician services. The status quo that had been effective in the past – solo providers, or physician "groups" that function as solo providers under a single corporate umbrella – will not ensure success in today's managed care-driven health care system.

As the downward spiral of reimbursement continues, physician groups are struggling to maintain and enhance income levels, while striving to provide the same quality service they have always provided. Groups that do not change their organizational and management approaches are experiencing the consequences: declining individual and practice income, the loss of patients to other providers, and continuous pressure to work longer hours.

In response, some group practices are taking a proactive stance in maintaining their livelihoods, while actually increasing the quality of care and service they provide. They are restructuring their organizations and staff to meet the demands of their new customers – the payers.

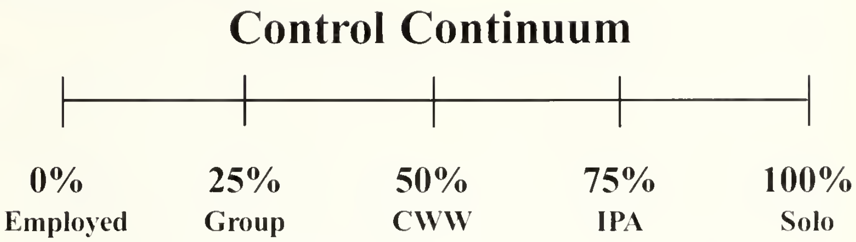
Payers now expect the following characteristics from their providers:

- **Documented high quality:** clinical paths, standard treatment protocols, physician practice guidelines, excellent outcomes, minimum volume thresholds for certain services, and patient satisfaction;
- **Documented low cost:** clinical paths, standard treatment protocols, physician practice guidelines, and more sophisticated cost accounting systems;
- **Contracting ease:** comprehensive services, package pricing of physician and hospital fees, and extensive geographic coverage.

These expectations must be the goals of every physician group that expects to thrive over the long term. To continue to be successful, physicians must not only meet these demands, but must do so in ways that maximize the use of their key resource: time available for patient care activities.

Physicians that spend their time on business management limit the amount of time they have to focus on activities that bring revenue to the practice – taking care of patients. And, physicians who ignore the business side of their practice find themselves struggling to realize income and life-style goals that were readily achieved in the past. This article explores ways of achieving the right balance through effective decision-making predicated on sound business principles.

Exhibit 1



Why Some Phyician Groups Don't Succeed Under Managed Care

According to Margaret Wheatley, a respected author on leadership, to create organizations that will be effective in a changing environment, "we need the courage to let go of the old world, to relinquish most of what we have cherished, to abandon our interpretations about what does and doesn't work."[1]

Many physician group practices are not thriving under managed care because the historical tenets of the practice of medicine are no longer appropriate and effective in delivering care today. The rugged individualism and autonomy that have been the cornerstones of medical practice preclude the organizational, management, and decision-making styles that are effective in the current health care marketplace. Unsuccessful group physician practices often have the following in common:

- **Unwillingness to relinquish control:** A key issue in the lack of success of some groups is control. A solo practitioner has 100% control over his/her practice; a member of a group practice has only 25% of that control. (Exhibit 1) Some physicians are unwilling to give up control, making an effective group practice impossible.

- **Autonomy versus centralized decision-making:** Clinically, the practice of medicine, by its very nature, rewards and cultivates autonomy. Physicians are trained to be decision-makers, and with every patient encounter, this posture is reinforced. However, the increasing demands on the business side of medical practice do not lend themselves to individual autonomy. Centralized decision-making is fundamental to a successful business.

- **Individualism versus collectivism:** Many physicians are also individualists, in part, a likely result of the solo practice of medicine, by far the most popular method of practice until recent decades. To succeed in the new payer-driven environment, however, physicians must work together – they must collaborate. An attitude of "what's best for the group is best for me" is critical to long-term success.

- **Lack of effective executive management:** Most physicians have little training or experience in the management of a large business; and, many seem reluctant to hire the experienced executive and technical personnel that are necessary to efficiently and effectively run a multi-million dollar business.

- **Micro-management:** With or without capable executive management in place, some physicians are hesitant to relinquish the helm. By getting involved in even the most minute of decisions, physicians undermine the authority of their managers and take time away from their patient care responsibilities.

How to Make Your Organization Effective Under Managed Care

Many physicians must be commended for having made the bold step of joining or forming a group practice/network. At times, however, they might wonder why they decided to do so. There is no quick and easy fix to make a group run efficiently and effectively in today's managed care market. The group must learn to follow basic business principles and to build the necessary clinical, operational, and informational infrastructures. This takes time, talent, patience, and capital.

The key to the success of any organization or business is its ability to make good and timely decisions. Good decisions are a product of accurate and timely information, an effective and efficient organizational infrastructure, and comprehensive and integrated business planning. Decision-making is a management process.

Continued on page 172

Continued from page 171

Management Information

Accurate and timely information has now become the key ingredient for success for corporate America, which includes health care delivery. The process of decision-making is not accomplished in a vacuum or from the "gut." It can only be achieved through an informational infrastructure that can produce current, accurate, and timely data with the necessary analytical tools/models to arrive at **information**. It is this **information** that affords the organization the ability to make good decisions.

The process of capturing accurate data in a timely fashion, analyzing it appropriately to create information, and then using this information to effectively make decisions, is essential to the success of any organization. Without the ability to collect and analyze information, the organization will continually spend its time putting out fires instead of improving the system.[2]

State-of-the-art management information systems (MIS) can be invaluable to group practice decision-making. To determine a group's needs relative to MIS, according to Elizabeth Meszaros, it is "helpful to think of an information system as an extension of the organization, a tool through which future goals can be achieved easily and cost-effectively."[3] To meet the demands of the managed care marketplace, a group practice MIS must integrate financial, administrative, and clinical data. It must also be flexible in meeting changing requirements. The system should enable data flow between the various providers in an integrated delivery system.

In addition to system requirements that have been around for many years – capturing of patient data, financial management, electronic claims filing, patient and physician scheduling, and word processing – the MIS should have a comprehensive cost accounting capability to enable financial analysis of group operations and contract evaluation.

On the clinical side, the system should be capable of using benchmarking and should be able to report variances from clinical standards established by the group.

The group should establish a standard set of management reports that are reviewed on a monthly basis by the Executive Committee. Statistical and trend analysis should be used to highlight changes in the group's performance and enhance the decision-making process.

Effective Organizational Structures

Organizational dynamics have been the subject of countless books and articles in recent decades. There are three key principles that we believe are critical to successful physician groups:

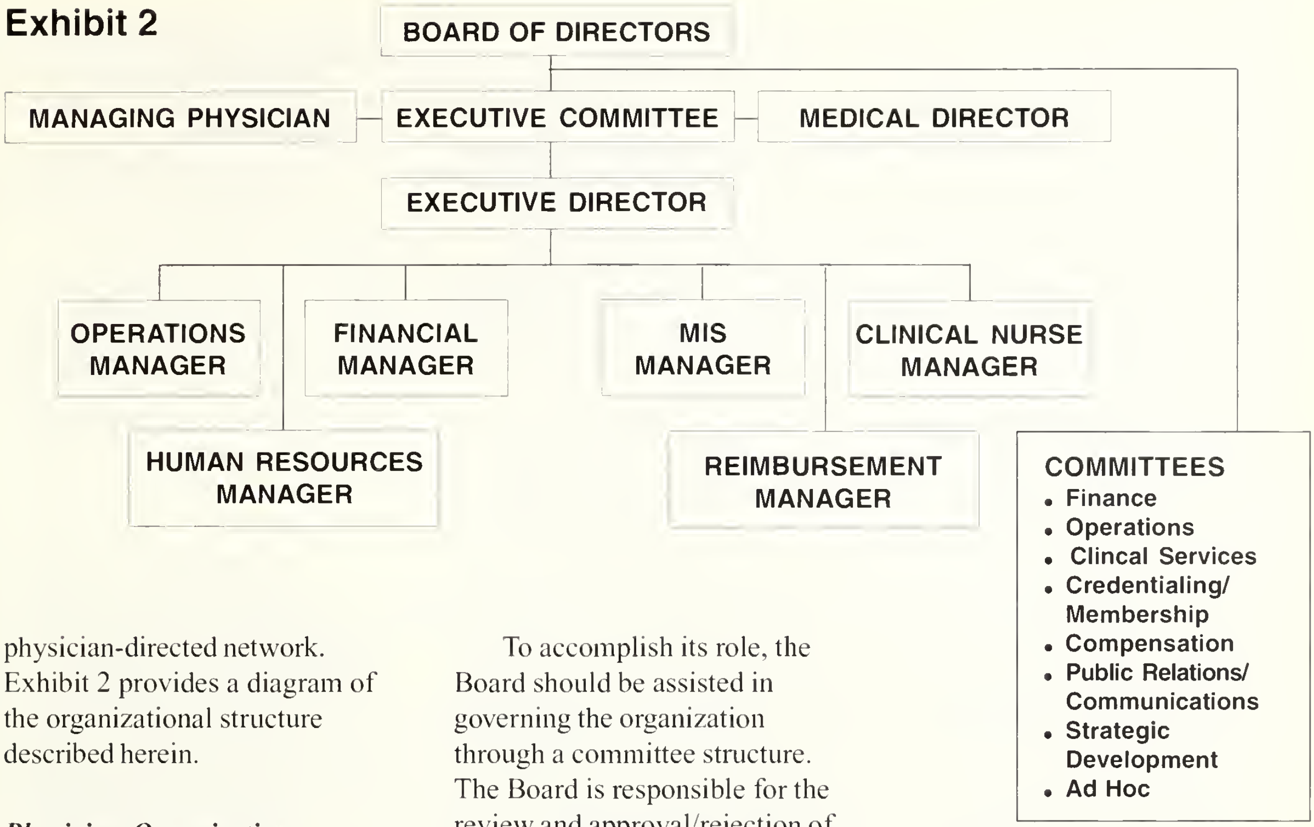
1. Individual needs are the driving force behind most of our actions and decisions. As human beings, we will generally act to meet our own needs; however, we will support the greater good, if the greater good appears to us to be what is best for us. To achieve success in today's market, physicians must learn to **think and act in a collective manner**.

2. Communication cannot be overemphasized. In the frenetic pace of the typical physician's day, there is barely time for the communication necessary to accomplish all the responsibilities surrounding patient care, let alone have time to communicate about the business side of the practice. A "conclave" philosophy must be avoided; **clear, complete, and regular communication is mandatory** for a physician group to achieve and maintain the level of integration necessary for long-term success.

3. Effective and efficient decision-making must be the ultimate goal of the organizational structure. Organizations function most effectively and efficiently when **decision-making authority is vested at the lowest appropriate level** in the organization. The proper organizational structure will facilitate decision-making, provide clear lines of authority and responsibility, enable appropriate supervision of employees, and delineate and enable an effective, formal channel of communication and information exchange.

These key principles must permeate the organization in order for it to achieve its full potential. The following is a "how-to guide" for integrating these principles into a physician group practice or

Exhibit 2


BOARD OF DIRECTORS
MANAGING PHYSICIAN
EXECUTIVE COMMITTEE
MEDICAL DIRECTOR
EXECUTIVE DIRECTOR
OPERATIONS MANAGER
FINANCIAL MANAGER
MIS MANAGER
CLINICAL NURSE MANAGER
HUMAN RESOURCES MANAGER
REIMBURSEMENT MANAGER
COMMITTEES
• Finance
• Operations
• Clincal Services
• Credentialing/ Membership
• Compensation
• Public Relations/ Communications
• Strategic Development
• Ad Hoc

physician-directed network. Exhibit 2 provides a diagram of the organizational structure described herein.

Physician Organization

Physicians in a group practice should have five levels of involvement in the governance and management of the practice:

1. Board of Directors
2. Executive Committee
3. Committees
4. Managing Physician
5. Medical Director

Board of Directors

The role of the Board of Directors is to approve policy and to set the overall direction, goals, and strategies of the organization in order to achieve its mission and vision. The Board of Directors should consist of a manageable group, i.e., between 9 and 11 shareholders, contingent on the total number of shareholders in the organization.

To accomplish its role, the Board should be assisted in governing the organization through a committee structure. The Board is responsible for the review and approval/rejection of the committee reports. Recommended committees and areas of responsibility include:

- Finance Committee
  - fiscal year budget
  - quarterly budget variance reports with trend analysis
  - monthly/quarterly financial reports
- Clinical Services Committee
  - UR/QA reports
  - Outcomes/clinical standards
  - Medical Director's report
- Credentialling/Recruitment Committee
- Compensation Committee
- Operations Committee
  - Productivity report
  - Human resources report
- Strategic Development Committee
- Public Relations/Communications Committee
- Executive Committee
- Any Ad Hoc Committees
- Executive Director's Report

The Board of Directors should meet at least on a quarterly basis. All meetings should be well-planned, staffed, and coordinated. The Board meeting should be conducted in a disciplined and orderly fashion, with a sense of fairness that permits reasonable debate based on fact and information. It is imperative that the Board does not become a time-wasting, debating society. To enhance efficiency, the agenda, minutes of the last meeting, reports, and recommendations on action items should be prepared and distributed to the Board at

Continued on page 174

Continued from page 173

least one week in advance of the meeting. *Note*: These recommendations apply to all group meetings.

The responsibilities of the Board members should be taken very seriously. Their duties and responsibilities should be clearly defined. There should be a system in place for the orientation and education of new Board members.

The role of the Board Chair, the formal leader of the group, is critical to the success of any organization. The physician leader must constantly keep the mission and vision of the group in the forefront. The leader must maintain guiding vision, enjoy his/her role in the group, be daring and take chances, and not be afraid of failure.

The leader must be able to effectively set the agenda and goals and **move** the organization towards those goals. The demands on his or her time will be excessive; he or she will be torn between governance issues, clinical duties, and family and social responsibilities. The time commitment on the part of the Chair should be carefully monitored, and if the demands on his or her time are excessive, then the Board should consider some form of compensation for that time.

The Board should function under the stated philosophy of "one person, one vote." Tiered shareholdership – with some physicians holding more voting power based on tenure, specialty, productivity, etc. – should not be permitted. The Board Chair will have the authority to break a tie vote.

Executive Committee

The heart of the organization is the Executive Committee. This Committee should be chaired by the Board Chair and should have no more than four other shareholders/Board members. The Executive Committee should meet once a month at a minimum, with weekly or biweekly meetings recommended as necessary.

The effectiveness of many organizations often rise and fall on the functioning and competence of this Committee. The role of this Committee is to provide assistance, guidance, and support to the Executive Director and to provide oversight to all aspects of the organization. In addition, the Executive Committee should coordinate the key functions of the various committees.

The key ingredient for the success of the Executive Committee is the use of good, accurate, and timely data/information to make decisions and formulate recommendations to the Board for approval. *Nota Bene*: There must be a balance of power/control between the Board, the Executive Committee, and the Executive Director. This balance is somewhat analogous to the judicial, legislative, and executive model of the U.S. government.

Committees

The committees listed above should be established to provide input, research, guidance, and objectivity into specific areas of the practice. These committees will make recommendations to the Executive Committee. Each committee will be chaired by a member of the Board of Directors. Committees should meet at least once a month.

It is critical that each committee (as well as the Executive Committee) be supported by designated non-physician staff to gather data and conduct the research and analysis necessary to ensure efficient and effective decision-making by the physician committee members.

Managing Physician

A Managing Physician should be elected from among the Board of Directors. The Managing Physician will be a member of the Executive Committee and will function as the liaison between the Board, the Executive Committee, and the Executive Director (see below). The Managing Physician will work with the Executive Director to implement the decisions of the Board and Executive Committee.

Medical Director

The Medical Director will be responsible for, and have authority over, clinical direction, standards, protocols, and guidelines. The Medical Director should also be elected from among the Board. The Medical Director will also be a member of the Executive Committee. In today's managed care environment, the Medical Director is a crucial position to ensure the group's competitiveness. The Medical Director will be responsible for developing clinical guidelines – both for clinical decision-making and utilization – and for monitoring compliance with these guidelines among the physicians in the group.

Non-Physician Management Structure

Critical to the success of physician organizations in a managed care environment is having highly competent, experienced non-physician management staff. The key role is that of the **Executive Director**. The Executive Director has the awesome responsibility of managing all aspects of the organization in order to achieve the mission and goals. To accomplish this responsibility, the Executive Director must be given the necessary authority and resources to build his or her management team.

The delegation of authority to the Executive Director should be clearly defined and approved by the Board of Directors. If there is ambiguity in this regard, it will quickly undermine and erode the effectiveness of the Executive Director. The Executive Director's responsibility/authority should include, but not be limited to:

- Operations;
- Accounts receivable management;
- Finance/accounting;
- Management information systems;
- Strategic planning;
- Managed care contracts; development and management.

No individual physician or roup of physicians should verride the decision of the xecutive Director concerning matters of Board-approved policy, guidelines, or protocols or Board-delegated areas of authority.

Non-physician middle management needs are dependent on the size of the group. At a minimum, there is generally a need for a manager responsible for each of the following areas: operations, finance, information systems, and clinical.

All non-physician personnel should report directly or indirectly to the Executive Director. There must be no "sacred cows."

Integrated Business Planning

The best practice organizational structure with highly competent individuals in all key positions carrying out their key responsibilities with proper authority, will still not function effectively without comprehensive, integrated business and strategic plans in place. Raymond Scroggins describes the "lack of plan syndrome" as follows: "Symptoms include communication breakdowns (sometimes so severe that partners won't speak to one another), inconclusive meetings, and other business problems that drain energies and create discontent."[4] An effective planning process, culminating in a statement of strategic vision, a comprehensive business plan, and a marketing plan, will help to eliminate these problems.

Strategic Vision

Comprehensive practice planning must begin with the development of a statement of strategic vision. For any organization to achieve long-term success, it must have a vision of what success is. That vision should then guide all planning and decision-making of the organization. The vision should clarify the organization's purpose and it must incorporate the values of the members of the organization. All those who are a part of the organization must understand and accept the vision as the definitive expression of the organization. Without such a vision, an organization is likely to be ineffective without focus and purpose.

The development of a strategic vision is essentially a consensus-building process designed to recognize and accept individual needs and goals to iterate who we are as a group and where we are going. Often, a day-long retreat involving all physicians and the Executive Director, guided by a skilled outside facilitator, can be very effective in hammering out a statement of strategic vision for the group.

Business Plan

Two specific plans derived from this practice vision are critical to group effectiveness and efficiency: the Business Plan and the Marketing Plan. The Business Plan is the road map that enables the group to achieve its vision. Exhibit 3, on the next page, illustrates the key components of the Business Plan.

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Exhibit 3 - Business Plan Components

I. Environmental Assessment
  A. Healthcare trends – national, regional, local
  B. Competitor analysis
  C. Payer assessment
  D. Referral analysis
  E. Service area demographics
II. Financial Assessment
  A. Operational performance
  B. Market performance
  C. Physician productivity
  D. Staffing analysis
  E. Activity-based costing analysis
III. Strategic Practice Positioning
  A. Practice vision
  B. Service strategies
  C. Market development strategies
  D. Management information systems and reporting requirements
IV. Operations Enhancement Plan
  A. Human resources plan
  B. Office procedures
  C. Practice standards – operational and clinical
  D. Facilities and equipment assessment
V. Contracting Strategies
  A. Contract evaluation methodology
  B. Contract acquisition strategies
VI. Detailed Implementation Plan and Schedule

Continued from page 175

Marketing Plan

Marketing is critical in today's health care environment. According to Bruce Berlow, MD and Douglas Trigg:

> *In today's highly competitive health care environment, marketing is becoming more – not less – important than ever. For decades, health care has functioned more or less as a cottage industry. It's no exaggeration to say that until just a few years ago, all a physician had to do to ensure a viable practice was to hang out a shingle. Product differentiation in a seller's market wasn't all that important.*
>
> *But today, the business of health care is finally beginning to function as a business. And, despite rapidly evolving market forces, it's unrealistic to think that any consumer-oriented business can survive without communicating its message to buyers: a process known as marketing. It's not so much that managed care has changed the role of marketing but that the target audience has changed.*[5]

The Marketing Plan should derive from the group's vision statement. It must be based on demographic analysis that can assist in predicting the future needs of the market. It should define the target audience; describe how the group will position itself within the market; identify specific strategies, objectives, and tactics for differentiating the group from its competition; delineate specific marketing techniques for reaching the target audience; and define the monitoring mechanism.

Conclusion

For many physician practices, preserving the status quo in the face of the rapidly evolving managed care marketplace has begun to result in declining revenues, lost patients, and hampered lifestyles. Specific strategies can be used to change this pattern. The organizations that establish effective, formal decision-making and management structures, led by highly capable and experienced executive management, can achieve the level of integration required for success in today's environment. This integration process coupled with proactive business planning and sophisticated information systems, can enable physician groups to thrive – not just survive.

"You can't solve a problem unless you first admit you have one." – ***Harvey Mackay***

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The Authors

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"Uninsured Missourians"

Pat Mills, CPA, MBA
MSMA Director of Health Care Finance

In late 1994, the Missouri Department of Health received a Robert Wood Johnson Foundation grant. With this funding, the Missouri Department of Health proposed to study the uninsured, to develop quality standards for uniform reporting of health data, and to analyze the economic impact of managed care in Missouri. The Partnership's goals include measuring and improving access, quality, and cost of health care in Missouri. Recommendations are to be provided to the Governor in July.

The Governor appointed 18 individuals from public, provider and purchaser sectors to form the Missouri Health Systems Partnership. Steven Buie, MD, a family physician in Lee's Summit and Lester Bryant, MD, Dean of the University of Missouri-Columbia School of Medicine, are the only MSMA members belonging to the partnership. Allen Daugird, MD, MBA, a family physician in Fulton serves as the director of the group.

Over the next two months *Missouri Medicine* will look at the Partnership's other phases. This month will highlight the information published in *Uninsured Missourians: Non-Elderly Missourians Without Health Insurance, 1991-1993*. The publication is available by contacting the Missouri Department of Health, P.O. Box 570, Jefferson City, MO 65102, (573) 751-0693.

In May, we will highlight the work done by subcommittees in identifying quality standards. Excerpts of the Lewin VHI report on the economic impact of managed care in Missouri will be featured in June.

Uninsured Missourians

The main data sources used in compiling this report was the combined 1991-1993 *Current Population Surveys* (CPS), U.S. Bureau of Census analyzed by the Urban Institute, Washington, D.C., and analyses of 1993 *Hospital Patient Abstract Records at the Missouri Department of Health Current Population Survey*.

The report estimates that 630,000 non-elderly Missourians were without health insurance in 1993. This is 14% of Missouri's children and adults under 65 years of age.

Missourians were analyzed by employment and income; employers of working uninsured; household and demographic characteristics; and, hospital usage and charges. *(See pages 164-165)*

The report also categorizes every county in the state by a range of rate per thousand non-elderly resident emergency room visitations, inpatient encounters, and amount of hospital charges per capita.

In 1993, health care charges in Missouri hospitals for non-elderly uninsured patients totaled $430 million, or about 8.2% of all hospital charges. No private insurance or public health care coverage was available in 18% of outpatient visits and 8% of inpatient hospitalizations. Total health care charges in 1993 for uninsured non-elderly Missourians were over $1 billion.

Assessment of the Study

As expected, low-income, single young adult Missourians were the most likely to be uninsured.

Most notable of the uninsured data is Missouri's unflattering comparison to the region and the country for uninsured by size of employer.

Continued on page 179

EMPLOYMENT

Health Insurance Providers for Non-Elderly Adults, Ages 18-64

	MO	*West North Central States	U.S.
Employers	**65%**	**66%**	**64%**
Uninsured	14	12	16
Medicaid	10	8	11
Other Private	9	12	7
Other Public	2	2	2
	100 %	100 %	100 %

*** West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota.**

Size of Employers of Uninsured Adults Ages 18-64

	Missouri	West North Central States	U.S.
< 25 workers	**41 %**	**46 %**	**48 %**
25 - 99 workers	16	16	16
100 + workers	**43**	**38**	**36**
	100 %	100 %	100 %

Employment Industry Missouri Uninsured Workers, Ages 18-64

Wholesale/Retail	**37 %**
Services	**35 %**
Manufacturing	12 %
Other	16 %
	100 %

Missourians, Age 18-64 with Employer Provided Insurance

Employees	33 %
Dependents	32 %
	65 %

Work Status Uninsured Missourians Age 18-64

Full-time	**56 %**
Part-time	21 %
Not Working	23 %
	100 %

Employment Sector Missouri Uninsured Workers Ages 18-64

Private	**85 %**
Self-Employed	10 %
Public	5 %
	100 %

HOUSEHOLDS

Household Structure Missouri Uninsured Adults Age 18-64

Married with Children	4 %
Single without Children	15 %
Married without Children	**47 %**
Single Parents with Children	**34 %**
	100 %

Family Income Missouri Uninsured Adults, Age 18-64

≥ 400%	4 %
200 - 399%	15 %
100-199%	**47 %**
< 100%	**34 %**
	100 %

1993 federal poverty guidelines: A family of four with an income of about $14,000 was at 100% of the Federal Poverty Level.

Age Groups Missouri Uninsured

< 18 years	26 %
18-34 years	**44 %**
35-54 years	23 %
55-64 years	7 %

Gender Missouri Uninsured

Male	54 %
Female	46 %

Race Missouri Uninsured

White	**79% ***
Non-White	21 %

***Although 79% of the uninsured in 1993 were white, many African-Americans and other nonwhites are at higher risk of being uninsured because of employment and income characteristics.**

HOSPITAL USE

Emergency Room Use
Non-Elderly Missourians, Ages 18-64

	Visits Per Thousand
Uninsured	425
Insured	276
National Average	**378** (all ages)

Inpatient Hospitalizations
Non-Elderly Missourians, Ages 18-64

	Visits Per Thousand
Uninsured	56
Insured	105
National Average	**129** (all ages)

Charges for Inpatient Hospital Care
Non-Elderly Missourians, Ages 18-64

	Per Visit
Uninsured	$ 603
Insured	**$ 1,063**
National Average	**$ 1,266** (outpatient & inpatient combined)

Visits for Uninsured
Non-Elderly Missourians, Ages 18-64

Inpatient	36,000
Outpatient	300,000

Average Statewide Rates by County
Non-Elderly Uninsured Missourians, Under 65 years

	Visits Per Thousand
Emergency Room Visits	59.52
Inpatient Encounters	7.86

	Per Capita Charge per each non-elderly Missourian
Hospital Charges	$83.37

UNINSURED MISSOURIANS

Continued from page 177

Not surprising are the data related to family income which bears out what has been accepted as common knowledge that families with incomes greater than 400% of the Federal Poverty Level (FPL) ($14,000 for a family of four) are included in the uninsured. Over 25,000 uninsured Missourians, or 4% of the total, have incomes over 400% of FPL.

Statewide in 1993, the use of hospitals by the uninsured differed from insured patients. Emergency room use rate was higher for uninsured compared to residents with health care coverage. In a similar vein, inpatient admission rates were lower for uninsured. Both of these compare favorably with national rates of emergency room visits and inpatient hospitalizations. Inpatient admission rates and per capita hospital charges were lower for the uninsured than for those with health care coverage. MoMed

HMO Operating Data
Note of Explanation

In the February 1996 *Missouri Medicine*, a table was published comparing HMOs operating statistics for the years 1992, 1993, and 1994.

CIGNA Healthcare of St. Louis has contacted MSMA to explain why their medical expense percentage was so much lower than other HMOs. CIGNA acts as a third party administrator for self-insured employer groups. For this service they receive payments for "ASO" (administrative services only) without reporting the related revenue associated with those covered lives. These ASO payments resulted in CIGNA medical expense being stated at 51% and administrative at 40%. When adjusted for ASO the medical expenses are 85% and the administrative 13%.

Is Health Care a Right?

S. D. Madduri, MD, Poplar Bluff, Missouri

Patrick (not his real name), a young man in his late twenties, came in for a testicular swelling and was found to have a hard nodule which in most probabilities did feel like cancer. He had to undergo surgery followed by radiotherapy and probably chemotherapy that could run into a few thousand dollars of expense.

He recently changed jobs and his insurance would not go into effect for a few months. He was married with two children and did not have any financial backup.

I sent him to a state-owned hospital, where he was told that he could not be treated free and the "discounted rate" he was offered was far beyond his reach.

Finally after three months of going from place to place and from agency to agency, I found a chief resident at a large university hospital to accept him. I was told that university grants could take care of his hospitalization as testicular cancer would be a good teaching case.

By the time of Patrick's operation, the tumor was found to have spread to his abdominal lymph nodes and he needed more extensive surgery, radiotherapy and chemotherapy. He and his family went through hell making those long trips for this treatments, staying in motels, etc. Patrick lost his job, was broke and was trying to restart all over again.

Howard, a 64-year-old gentleman, worked for an insurance company selling insurance to school teachers statewide. His job required constant travel and at his age he decided to retire as the long hours one the road were taking a toll on his health.

He would lose his job-provided health insurance upon his retirement, but could pick up Medicare. However, his wife would be left without health insurance. She was 60 years old and had to wait for four more years before she would be eligible for Medicare. She had surgery for breast cancer when she was 50 years old. A couple of years following surgery the cancer was found to have spread to the brain. She required more surgery and chemotherapy and was stable but needed constant medical attention and tests.

With her preexisting conditions Howard had trouble finding an insurance company that would be willing to insure her. The couple of companies that were willing to do so quoted their premiums so high that they were not within his reach.

So, as of today, Howard is working with the same insurance company spending five days a week on the road to his bitter dislike.

These are only a few of the many tragic stories that are tearing apart the fabric of our society. Medical care in the U.S. today dictates the essence of our lives. It tells us when to get married, when to have children, when to get a divorce or when to live together without getting married and of course, when to change jobs, and when to retire.

Health care in the U.S. is an excellent example of an "all or none" phenomenon. People who have insurance and who can afford it will be catered to the best medical care in the world, and those without resources will have none.

Astounding statistics tell the horror story of inadequate health care in our country today. Approximately 50 million people have little or no health insurance. Eighty million people with preexisting conditions pay premiums, often as much as $11,000 a year, for policies that do not cover their illnesses. It is not the poor and the indigent that are being affected, as they will qualify for Medicaid, but the working, middle-class that fall through the cracks and are left out in the cold.

Unfortunately, Americans accept the present health care system as the Biblical truth. We believe that our forefathers gave us life, liberty and the pursuit of happiness. These are our unalienable rights guaranteed by the Constitution. We are made to believe health care is not a given right.

The U.S. is the only country among the industrialized nations, in fact in the whole world, where basic health care is not universally available to all its citizens. We are the only people on the globe who live in constant fear of getting sick if we do not carry enough insurance. One major illness in the family can wipe out our entire life savings.

One has to realize that the pursuit of happiness, an unalienable right, is possible only with healthy body and sound mind. Although our founding fathers did not spell out health care in their "Bill of Rights," it is implied as a needed ingredient in the recipe for the "pursuit of happiness." Health care, it should be understood, means basic health care that is needed to treat a sick person and should not include face lifts, tummy tucks and liposuctions.

However, the dreaded unanswered question remains: Who is going to pay for it and how is it going to be financed?

Before we can think of paying for new programs, we should make an attempt to clean house. The skyrocketing health care costs in the U.S. today are due to multiple factors. The malpractice crisis is forcing doctors and hospitals to practice defensive medicine accounts for 15 to 20% of the health care budget. The ever increasing administrative costs in a community hospital are estimated to average an obscene $2-4 million a year for paperwork. It is the middle man in health care who is costing another $100 billion!

If all this waste were to be removed, the U.S. could provide health care to all its citizens and would save $175 billion a year. People who cannot afford to pay the exorbitant private insurance premiums, will be able to buy into the government-sponsored health care. MoMed

April declared as Immunization Month

National Infant Immunization Week ▸ April 21-27, 1996

It's a Fact: In 1995, the Department of Health released a study by the National Centers for Disease Control that showed only 64% of Missouri two-year-old children were immunized. Early 1996 studies estimate that Missouri has climbed three percentage points closer to its goal of 75%.

Here's what you can do to help raise these rates:

- ✔ Participate in National Infant Immunization Week, April 21-27
- ✔ Provide brochures with recommended immunization schedules to all patients and encourage them to know the immunization status of their children.
- ✔ Display posters in waiting areas, reception areas, and cafeterias.
- ✔ Use reminder/recall systems, self-assessment of immunization records, improved record-keeping systems, and immunization schedules on charts.
- ✔ Volunteer your time at local clinics.
- ✔ Write editorials and letters to the editor of your local paper promoting immunization.

For materials and information on immunization, please contact the Missouri Department of Health, Bureau of Immunization at 573-751-6133.

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Pneumothorax Detection in Patients with Apical Pleural Caps

James K. Fisher, MD and Richard T. Falter, MD

The usual small apical pneumothorax has been previously described as being typified on chest radiographs by a pencil-thin white line that represents the retracted visceral pleura. Occasionally the apical visceral pleura can become thickened, known as the apical cap, which leads to a variant presentation of apical pneumothorax. To our knowledge, this variant presentation has never been described in the literature, and should improve the detection of apical pneumothorax.

Key Words:
Pneumothorax
apical caps (pleural thickening)

Usually, an apical pneumothorax is easy to identify and diagnose on an upright chest radiograph. The presence of apical capping, which denotes thickening of the apical visceral pleura, is a relatively common chest film finding. When apical pneumothorax coexists with apical capping, diagnosis of pneumothorax could potentially be overlooked secondary to this variant presentation. This pictorial essay simplifies this problem by pointing out the needed details to make the diagnosis.

Discussion

A pneumothorax is generally easy to recognize on a chest radiograph. This entity occurs when the visceral pleura becomes retracted away from the parietal pleura due to air within the pleural space. Classically, the pneumothorax has been described as a thin radiopaque, curvilinear line seen lying between the aerated lung and the radiolucent air contained in the pleural space.[1,2,3] Ordinarily, the visceral pleura is paper thin and characteristically measures 0.1 - 0.2 mm in thickness when seen in profile in patients with a pneumothorax (Fig 1). There are other signs of pneumothorax, such as focal radiolucency or paucity of lung markings in a certain area of the chest. These findings are easy to see when the pneumothorax is large, but more difficult to use as diagnostic criteria when the pneumothorax is tiny. Identifying the **thin** visceral pleural line is the most accurate way to identify a minimal pneumothorax.

Conditions may arise which lead to thickening of pleural surfaces, and in these circumstances, the pneumothorax edge may not have its characteristic appearance. This thickening has been reported to be a response by the pleura to a variety of etiologies ranging from scarring of obscure etiology (most common) to scarring from post-inflammatory disease (TB, abscess/emphysema), trauma, neoplasm, radiation, asbestos, and collagen vascular disease.

Pleural thickening that occurs in the lung apex is known as a specific entity called an "apical pleural cap." An apical pleural cap is a homogeneous, soft tissue opacity found at the apex of the

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lung, in the concavity formed by the first and second ribs.[2,4,5] (Fig.2a) The lower aspect of this curvilinear thickening is usually sharply marginated, and generally measures less than 5 mm in thickness. This thickening increases with age and can be unilateral or bilateral. When seen bilaterally, its appearance can be asymmetrical and calcifications may occasionally be present. Pathologically, this pleural cap is formed by various amounts of hyalinized collagen tissue or a subpleural scar which merges with the thickened adjacent visceral pleura.[4,6,7] Its etiology is usually idiopathic, probably secondary to chronic ischemic changes and gravitational stress. While tuberculosis was once suspected to be its etiology, this has not been proven to be the usual cause.

When apical capping is present, an opacity is seen which traverses the apical lung region and may mimic rib cortex (Figs 2B, 3A, 3B). When seen on a chest radiograph, this could not only be mistaken for a rib, but other overlying structures such as a vascular catheter, clothing, scapula, skin fold, subclavian artery, or even a rib companion shadow could be confused with it. Thus, being able to recognize the presence of pleural capping is of important clinical significance as failure of recognition could lead to overlooking the presence of a small pneumothorax.

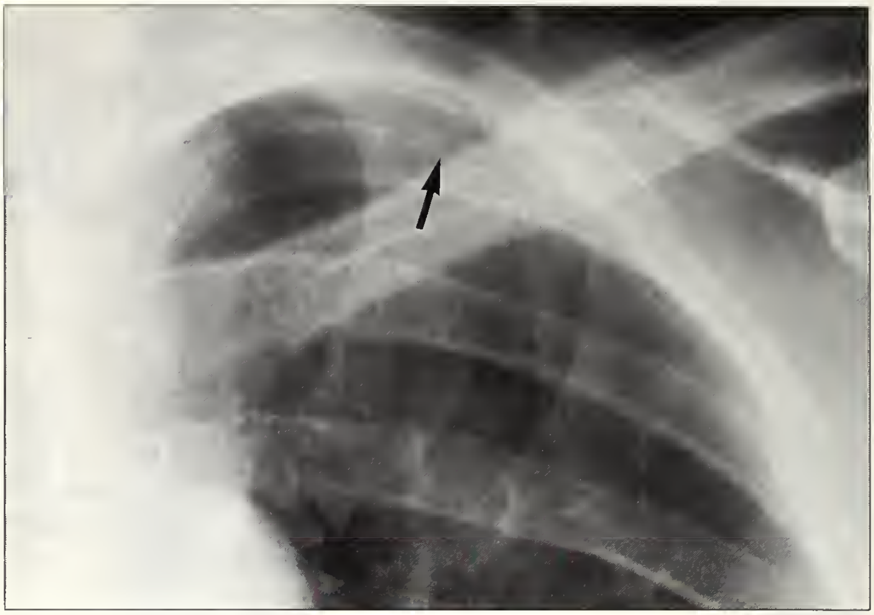

Figure 1: The arrow points to the typical appearance of the thin visceral pleural edge that has retracted away from the parietal pleural chest wall in a patient with a small pneumothorax.

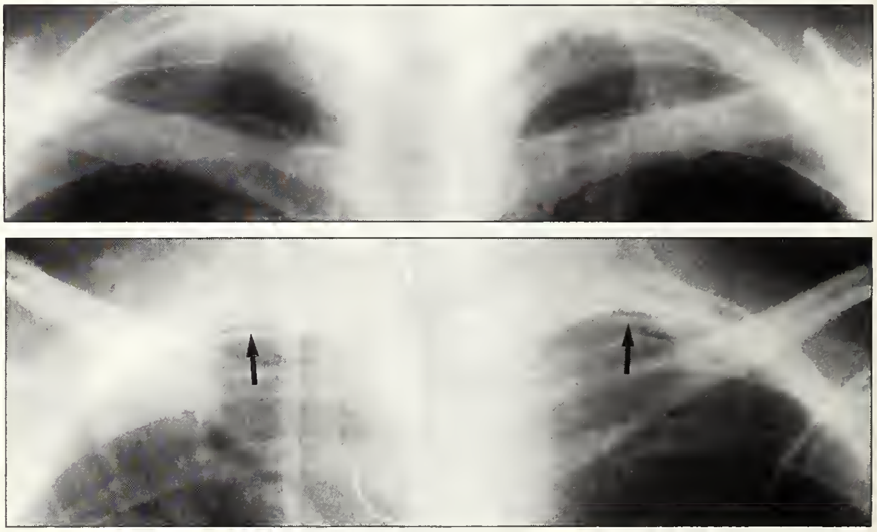

Figure 2A: Typical apical pleural caps are demonstrated bilaterally. Figure 2B: Same patient as in 2A, but now demonstrating tiny bilateral apical pneumothoraces. The arrow denotes a broad lung edge opacity representing the apical cap that has retracted away from the parietal pleura.

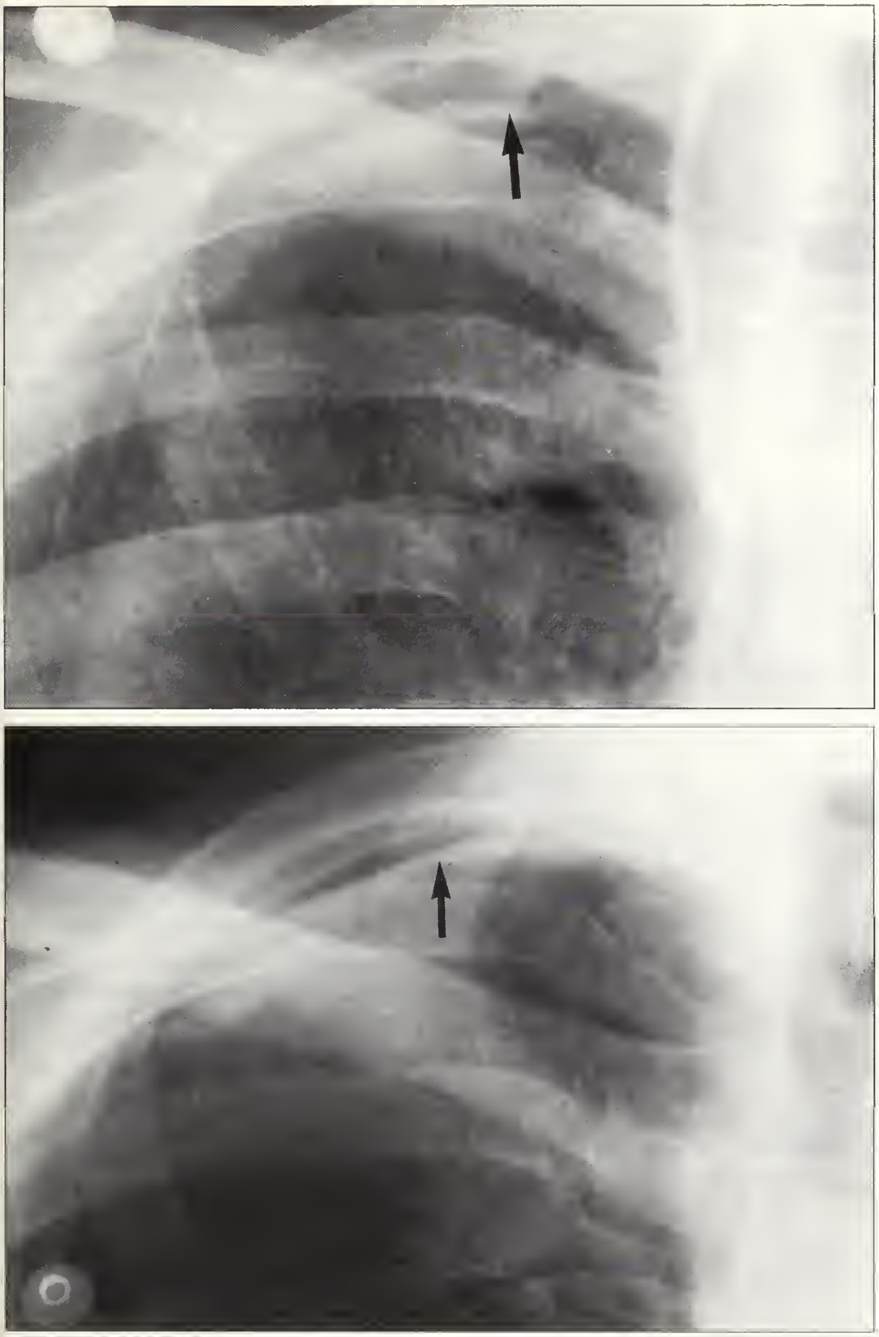

Figure 3A,B: These different patients demonstrate the typical appearance of tiny pneumothoraces with coexisting apical caps. The arrow points to the broad lung edge that represents the visceral pleura and underlying scarred lung apex.

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Missouri Medicine

Journal of the Missouri State Medical Association
May 1996

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On the Cover: "Bright Eyes and Stones" is a watercolor painting by Terry Martin. Mr. Martin is an instructor of art at William Woods University in Fulton, Missouri.

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Mega-bytes Delights

J. Regan Thomas, MD, Editor

The medical community often extols the public to take responsibility for their own health. Recommendations to patients typically include smoking cessation, increased regular exercise, dietary precautions, and appropriate medical check-ups and screenings. Recently patients have more frequently discussed and questioned their care decisions in a more interactive way than in the past.

One such change has come from pharmaceutical company advertising of prescription drugs. Ads are placed in lay publications which describe and recommend specific prescription drugs. Patients are urged to ask their physicians to consider prescribing that specific medication. Already enormous ad campaigns have been used in both the print and electronic media for prescription medications including cardiac medications, hair restoration solutions and topical nasal steroids. The drug companies no doubt would rationalize the ads as patient education and of course would point out the disclaimers which note that "your own physician is always your best source of medical advice." You be the judge of the real intent.

Now a new medium (or maybe make that "modem") has entered the relationship between physician and patient. As more and more people have computer links with the World Wide Web they are beginning to utilize a variety of medically related databases more often. Physicians should expect more patients to have information related to their illness obtained through computerized services. In fact physicians need to become accustomed to patients getting second opinions, or perhaps second guessing their diagnosis, with information from their computer networks.

An article in the Feb. 21 issue of *The Wall Street Journal* notes that the National Library of Medicine in Bethesda, Maryland says that the information downloaded from its computer database of medical journal abstracts has more than doubled in the past five years. Although this giant database, Medline, is intended for doctors, the general consumer use continues to grow.

Recently, entrepreneurial companies have begun to develop medical information databases aimed specifically at consumers. For example, Health Gate Data Corporation, targets consumers through its web site. *The Wall Street Journal* notes that Health Gate is visited on the Web by over 30,000 people a day after being on line only two months. They attract consumers by using "plain English" descriptions rather than medical jargon in their software. The Web site user can search through "heart attack" for example, instead of "myocardial infarction."

As more of these services become available to the growing population of computer savvy patients, physicians must be ready to adapt to the change. On the positive side of this new information era should be a better informed patient. The more knowledgeable the patient, the more likely they will make wise health decisions. The well-informed patient should be expected to better follow directions and make superior health oriented decisions.

There are concerns about some negative impacts of this growing database. The more hypochondriacal patient may find even more to worry about. Since most of the information is from professional or technical journals, it contains information that may be confusing or misleading to any patient. We are as physicians aware of early, preliminary, or statistically insignificant studies showing up in the literature. The less sophisticated reader may have false hopes or unwise decisions as the result. The cliché "knowing just enough to be dangerous" comes to mind.

The best course of action for the physician is to understand the situation and expect to see this new phenomenon in his or her practice. The wise physician will likely use this new technology to benefit his or her own information base. Knowing what your patient is reading about their diagnosis will help you lead those patients in the proper direction. This is technology that can not be ignored and will only continue to grow. It must be incorporated into the culture of medical practice just as it is being absorbed by our culture at large. **MoMed**

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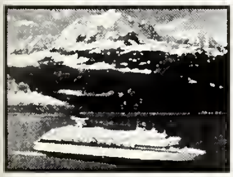

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Presidential Address by Frederick Hahn, MD

Presidential Address given by Dr. Frederick Hahn, April 11, 1996 during the First Session of the House of Delegates in Salon B at Marriott's Tan-Tar-A Resort, Osage Beach.

I can't tell you how glad I am personally to be here. My wife and I have just returned recently from a trip to India. To brush your teeth with the tap water, to crawl into bed where there are not some friendly compadres with more than two legs, and to have the enjoyment of eating just anything set before you is, indeed, a pleasure. So, for many reasons we are glad to be here and share the company and the food.

It's a commonly known fact that the health care industry today is a major target for speculative investing.

While the house of medicine is in a state of disarray resulting in great part from federally-conceived restraints, insurance companies are mercilessly and lustfully pilfering the system under the guise of managed care.

In the late 1980s, the island of St. Thomas in the Caribbean was struck by a hurricane. Prior to this time, the island was quite a little paradise for both tourists and local merchants. With the hurricane, looting became common. However, even after nature's disaster, humanity's indiscretions continued. The taste of something for nothing became like blood in shark-infested waters.

As buildings and businesses were restored to their pre-catastrophe condition, the feeling of safety and serenity did not return.

Looting and thievery continued to the point that the store owners could no longer leave their places unattended for even a brief period of time without the fear of intrusion and theft.

In fact, armed guards must now be posted on the roof tops and at other strategic points in order to protect business property.

It is my understanding that this condition has even worsened and has done so incrementally following the hurricane this past fall.

The profit margin for business people on the island was already narrow. With a relatively fixed amount of traffic and a fee schedule bracketed by the marketplace on the neighboring islands, the merchants could ill afford the cost of hired security and much less the ravage of their places of business.

Tourism has been constrained by the above sequence of events, while innumerable merchants have been irreversibly damaged.

Those of us who represent professional health care—like the merchants on the island of St. Thomas—have something very basic in common. In each case, our very existence hinges on our ability to wrestle our businesses away from unscrupulous looters.

It is my firm belief that our only hope for success is to unify our efforts and to work collectively for the benefit of all concerned.

It further seems to me that a key to any anticipated success is not our current focus on selfish subspecialty interests or purely financial considerations. Rather our single worthy focus is directing flawlessly ethical health care to the people of our fair state of Missouri.

We have a collection of the greatest scientific minds in the world. We have the benefit of the finest institutions of learning in history. We have instruments which could only be available in a space age.

Collectively, we have the potential to deliver progressively better health at a rate parallel to the digital communication explosion.

We dare not allow the goals entrusted to this grand and proud profession of medicine to be frustrated by the knavish perpetrators of the litigious mania or the base morality of bottom-line management.

We must bond with those with whom we serve and those whom we serve. The federation of medicine offers us a vehicle to accomplish this honorable task.

Let us not squander that opportunity. **MoMed**

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Daniel F. O'Sullivan, MD, Installed at the 138th Presidential Inaugural Ceremony

Presidential Inaugural Address given by Dr. O'Sullivan, April 13, 1996, in Salon B of Marriott's Tan-Tar-A Resort, Osage Beach, Missouri.

Frederick Hahn, MD, presents the Presidential Medal to newly installed MSMA President Daniel O'Sullivan, MD.

Monsignor Wilkerson, Mr. President, distinguished Past Presidents, honored guests of 1946, other distinguished guests, ladies and gentlemen:

As I stand here this evening and review the list of Past Presidents, and as I take the gavel from Dr. Fred Hahn of Independence, the seriousness of the responsibility of this office is suddenly real and apparent. Dr. Robert McAfee, Immediate Past President of the AMA, and a surgeon with a great sense of humor, said "Being president of this organization is like being the caretaker of a cemetery. There are a lot of people under you, but none of them seem to be listening."

We will move together this year to consider all the challenges of medicine and prepare for the 21st Century. As we approach that challenge, let's see where we've been, where we are, and where we are going.

In recent years business people have tried to recodify doctors as providers and patients as either clients or customers. I think most of us find this offensive and part of the depersonalization of medical care. The position of respect that physicians have occupied over the history of man is an attribute that we all treasure. Recent erosion of this admiration by our patients is a product of commercialism, legalism and to a significant extent, the attitude that we and some of our peers have allowed ourselves to slip into as a result of many forces.

It is to the advantage of business to treat and consider doctors and nurses as just another workforce occupation. Once they have permanently established such a scenario they can then insert themselves over us as controllers of business and controllers of action, and determine our workplace, our working conditions and the limitations on our professional activities.

The legalistic side of deprecation of medicine is related to continuing litigation against physicians in both the civil and the malpractice arena. We are in open court described as butchers, thieves and worst of all, buffoons who fail to exercise the degree of skill and judgement which would ordinarily be exercised by a physician in same or similar circumstances.

Our own liability, however, for this change in attitude arises from a demeanor which patients sometimes interpret as arrogance, perhaps partly because of the buffeting we have received from outside sources and perhaps because we have come out of focus with the proper perspective of patient care. Some of us fail to show the proper respect, fail to accord the deserved dignity or even just do not pay attention to our patients as they seek our advice and assistance.

Other factors could be included in the analysis of the decline of the image of the doctor. However, as we stand here in 1996 on the dawn of a new century and on the forefront of telemedicine, it is a time when more than ever the practice of medicine is at the crossroads of being a profession or just an occupation. Let us this evening look back over the history of medicine and pinpoint just a few of the important moments in the history of medicine which had to do with the relationship between the person delivering medical care and the recipient of that care – in the hopes that we can get a little better understanding of what the doctor-patient relationship is really all about.

It all began with Adam and Eve in the Garden of Eden. As we have all been taught, Adam and Eve had access to all the wonders of the Garden of Eden except that they were not allowed to eat the fruit of the apple tree. Now this is one of those few places where the bible is mistaken because Eve knew from her personal experience that Adam had a sweet tooth so she picked apples from the tree and made an apple tart. When Adam saw this flaky apple tart, he could no more resist the temptation than he could that of this shapely wife. Not being schooled in self control, Adam quickly ate the apple tart. Then the bible was back on track and records that God condemned Adam and Eve, drove them out of the Garden of Eden to live their lives out on Earth. God was the sole judge, he was the jury, and he made this decision. As they left the pearly gates Adam proclaimed, "It isn't fair, it isn't fair." And this, ladies and gentlemen, was the first instance in the history of medicine of demands for tart reform.

Years later Earp, a caveman and a descendant of Adam, was cooking a rabbit over an open fire to serve dinner to his wife Hillary. The smoke of the fire caught the attention of Heimlich who lived in the next cave. Earp decided to taste a bite of his bunny and swallowed a rabbit bone and began to choke. Heimlich came running over as Hillary came out to view the accident and Heimlich grabbed the other caveman from behind and put his hands around his waist and made him earp. Heimlich's maneuver saved the other caveman's life. As they stood there grunting affectionately, Earp ripped off a hindquarter of the rabbit and gave it to his neighbor. You think I'm going to say that that was the beginning of the Heimlich maneuver but in truth this was the origination of fee for service.

As Lot and his wife fled from the city of Gomorrah, the Lord advised them not to look back. Lot herded his children before him as he fled away and could not look back, but his wife – what can I say – turned as we read, was transformed into a pillar of salt. Lot's heart was broken, and there for the first time it became known that salt was bad for your heart.

Joseph and Mary, the new testament tells us, traveled across from Nazareth to Bethlehem so that they could register for the census. But why did Mary, Joseph and Jesus have to stay in little manger out in the back? Because they had no precertification from the Nazareth HMO.

Atilla the Hun was charging his enemies and slaughtering them as they came by. One of his lieutenants came to him and said, "Master, what shall we do with our wounded? They lie everywhere," and Atilla said, "Kill them all." This was the first known medical plan.

The time was the Middle Ages in Europe. The great plague was sweeping through Europe. The tired physician said to the sister, the nurse at the hospital, "But sister, we must test this patient for the plague whether he wants the test or not. This disease represents a threat to the entire community." "No doctor," the sister said. "Test for plague cannot be conducted without proper permission from the patient. The reason is, it's at that first interview that we are able to properly counsel that patient about his own preferential behavior. Individual rights supersede the rights of society to know."

Over the years many landmark events have been noted in medical history:

470-400 BC	Hippocrates of COS.
150-199	Galen (Anatomy, Pathology)
600	Chinese surgeons removed cataracts
1342	Hernia and cataract surgery at Avignon
1346-53	Great Plague
1543	Vesalius (Anatomy)
1563	Ambrose Pare - five books on surgery
1619	William Harvey described the circulation of the blood
1785	Digitalis introduced into scientific medicine (William Withering)
1793	Yellow Fever in Philadelphia
1821	Morphine in medical practice
1842	general anesthesia
1867	Lister (Phenol)

One hundred years ago, in 1896, medicine was entering what we might call its modern age - this was the time of the "horse and buggy doctor." Doc Adams clinking the bullet in a metal pan (always metal) after he removed it from the hero's heart, and always resulting in the perfect cure: "There, I got it out." This is our concept of frontier medicine. Then, as now, the only real doctors were in Boston.

The president of United States was Grover Cleveland. William Jennings Bryan, "The Golden-tongued Orator," was the democratic candidate, but William McKinley was elected in November.

Utah was the 45th state and gold was discovered in the Yukon Territory resulting in the "Klondike Stampede." Louis Pasteur and Nobel died. Konrad Roentgen showed the medical use of x-ray and Marconi patented the wireless telegraph. Henry K. Sienkiewicz wrote *Quo Vadis,* and on August 31, 1896 professional football was born when a quarterback was paid $10 to play a game. Lon Vest Stephens was Governor of Missouri, John H.

Continued on page 204

Continued from page 203

Duncan of St. Louis was President of MSMA and A. F. Dressel, Corresponding Secretary. A state legislative bill suggested the creation of a state license to be conferred by the State Board of Examiners. This would be different from a degree. Doctors were gaining respect as professionals and considered such topics as "Gastrotomy for the Removal of Foreign Bodies from the Stomach" and "Laboratomy Endowment and the Value of Lab Work." Sigmund Freud founded psychoanalysis.

It was a free and easy time in medicine and the 20th Century was anxiously anticipated. Ronald Ross discovered the cause of malaria, later confirmed by Walter Reed. Chiropractics was begun by David D. Palmer. My father-in-law was born.

Seventy-five years ago, 1921, was an important year in medicine and the world. World War I had ended in 1918. Woodrow Wilson had been president of the U. S. 1913-21 and Warren G. Harding assumed office in 1921. Arthur Mastick Hyde was Governor of Missouri and A. H. Hamel, MD of St. Louis was president of MSMA. E. G. Goodwin was secretary and editor.

The 19th Amendment was passed by which women received the vote. The League of Nations met. Prohibition was in effect. The world was still turbulent and Northern Ireland separated from the Irish free state. Mussolini marched on Rome and the Chinese Communist Party was founded.

Albert Einstein won the Nobel Prize in Physics ($E = MC^2$). Jack Dempsey knocked out Georges Charpentier of France in the fourth round and Enrico Caruso died.

Medicine was busy – Banting and Best prepared insulin in Toronto and used it on humans. MSMA dues were increased from $3 to $5. Articles appeared in *Missouri Medicine* on rural sanitation in Missouri. Much attention was paid to quackery and medical pretenders. MSMA opposed bills defining and regulating chiropracty and optometry and opposed their treating patients in Missouri hospitals.

My wife's father, W. A. Monaghan, graduated from St. Louis University School of Medicine and drove 100 miles northeast to Illinois to open a family practice with his new bride. He spent 34 years in Taylorville and became the hero of the community. Everyone recognized him walking down the street. Since he was one of the few citizens with a car, house calls were a must. He was indeed the most respected man in town.

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Dr. O'Sullivan giving his Presidential Address.

His stories were wonderful. Once, when a senior student, he and a classmate left City Hospital in St. Louis to perform a home delivery. Dr. Monaghan fell asleep on a chair as the expectant mother lay moaning on her bed in full labor. The other student, equally exhausted, sat on the corner of the bed and soon was supine in sleep. The surprise came when the patient's husband arrived home to find a young man sleeping on the bed and a second in the chair as the baby arrived.

Fifty years ago, 1946, was a wonderful and exciting year throughout the world. Of course Harry S. Truman of Independence, Missouri was president and there was no vice-president – who needed one! Governor of Missouri was Phil M. Donnelly. Howard B. Goodrich of Hannibal was President of MSMA and Tom O'Brien was executive secretary. Important world events were:

1) United Nations actions of security council and general assembly; we learned the meaning of "nyet";
2) Nuremberg trials;
3) Atom bomb tests - Bikini Atoll awesome destructive capability;
4) Great coal strike made John L. Lewis a household name;
5) National congressional election left a democratic president with a republican senate and house virtually guaranteeing a defeat for Truman in 1948;

Caduces - The Doctors' Band provided musical entertainment during the Presidential Installation and big band dancing at the Presidential Reception.

6) Passing of a OPA price controls opened the door for inflation.

Of the Nuremberg verdicts, H. V. Kaltenborn, renowned newscaster said, "For the first time in history a legal precedent was established making rulers of nations liable for their action before the world...the four nations which now rule the world must remain at peace. If they fail, war will again have to decide who the defendants and who the judges will be at the next war-crimes trial."

Best books included: *The Egg and I*; *Animal Farm* by George Orwell; *Brideshead Revisited* by Evelyn Waugh.

Best movies: *Best Years of our lives*; *Bells of St. Mary's*; and, *The Outlaw*.

The Vietnam revolt began in Indo-China. VA was established. Commercial television appeared. The St. Louis Cardinals beat the Boston Red Sox (Musial V. Williams) in the World Series.

The Mayo Clinic said, "Streptomycin seems to check tuberculosis but is too toxic for wide use." There were 4,167 cases of infantile paralysis reported by July 27, the nation's worst epidemic in 12 years.

The Nobel Prize was won by Professor Herman J. Muller, an Indiana University geneticist, "Mutations caused by x-rays," based on studies of victims of Hiroshima and Nagasaki.

About 50 miles from where we sit, at Westminster College in Fulton, Missouri, a brilliant politician said, "From Stettin in the Baltic to Trieste in the Adriatic, an Iron Curtain has descended across the continent."

My father in St. Louis and my father-in-law in Illinois continued their family practices armed with the discovery of penicillin by Fleming in 1928, vitamins A, C, E and K, and amphetamines. Technology was improving and accessibility and cost of health care began to climb. Doctors, priests, ministers, and rabbis were held in equal high esteem. Times were good!

Our honored members entered a world of medical opportunity. Retiring President A. S. Bristow of Princeton, Missouri, read his message and recommendations. Included was a plea for support of Missouri Medical Service, a non-profit organization by the doctors of Missouri, known as Blue Cross.

Twenty-five years ago, 1971, Richard Nixon was President and Spiro Agnew was Vice President. When asked what Spiro Agnew was, one comedian answered "I don't know, but penicillin should make it go away." Warren E. Hearnes was Governor of Missouri. Gerald L. Miller, MD, of Kansas City, was MSMA President and Ray McIntyre was executive director. Nelson Rockefeller was Governor of New York and Ronald Reagan was Governor of California. Edmund Muskie was endorsed as presidential candidate by Governor Hearnes and Senators Stuart Symington and Thomas Eagleton.

The Vietnam War dragged on. The U. S. invaded Laos. Idi Amin overthrew Milton Obote in Uganda. Bengladesh declared is independence. Lt. William Calley Jr. was convicted of the My Lai Massacre and sentenced to life, got a reduced sentence, and eventually the conviction was overturned.

The FTC warned the nation's six major cigarette manufacturers that it would take them into court unless they agreed to include "clean and conspicuous" health warnings on their advertisements. A ban on TV cigarette advertising was enforced.

Apollo 14 and 15 landed on the moon. Disney World opened in Orlando. Nikita Kruschev died. "Papa Doc" Francois Duvalier died and was succeeded by his son, Jean Claude "Baby Doc" in Haiti.

Albert Sabin won 1970 Medal of Science for developing polio vaccine named for him. Earl Sutherland, professor of physiology at Vanderbilt, won 1971 Nobel Prize for work with hormones.

President Nixon addressed the AMA convention calling on them to join the administrations fight against drug abuse. He also assailed a proposal for "nationalized compulsory health insurance."

Continued on page 206

The Presidential Inauguration ceremony also recognizes physicians who have practiced for 50 years.

Continued from page 205

The French Connection was the Picture of the Year. Joe Frazier outbouted Muhammad Ali and Simon & Garfunkel sang "Bridge Over Troubled Waters."

Insurance company intervention in medicine grew in a "payor's revolution" in response to rising cost of care - Medicare was four years old. Issues were national health insurance, the enviable record of AMPAC, and physician shortage. Transfusion of blood and transplantation of organs is not a sale and "no warranty implied."

The remarks of Dr. Gerald Miller were scholarly and to the point. I considered just reading his speech. However, it is noteworthy that the medical society was fighting a shortage of manpower, resulting in the opening of UMKC Medical School: "The Government is going to have an expanding role in at least the financing of health care."

1996 is a year which looks back on a century of events which have changed the face of the world, the face of medicine and the position of the physician in the arena of society.

Of course, the president is Bill Clinton and the Governor Mel Carnahan. Together in 1993 they attempted to pass federal and civil health care reform bills which would have destroyed private practice as we know it and erased forever the doctor-patient relationship. The people soundly rejected this concept. This was the best thing President Clinton could have done for us because it awakened some physicians who have done nothing but complain for 20 years and brought them to their feet. Some of us are still standing. Dr. Jerry Murrell, who retired last year as President of MSMA, provided us with legislative guidance and continued this year as Legislative Affairs Committee Chair. Dr. Fred Hahn has just completed a year of outstanding service as president and has held firm the patient advocate posture of MSMA.

We are in the midst of a price revolution, a money-driven industry in which we can't compete because the rules aren't fair. Well, the rules need to be changed.

Since 1971 we have seen enormous technological advances in imaging, with computerized tomography, magnetic resonance imaging, and ultrasonography. We have improved immunizations and we have identified acquired immune deficiency syndrome - AIDS, the first infectious disease which seems universally fatal.

We have "peek-a-boo" surgery through the laparoscope, the arthoscope, and the operating microscope. We have unbelievable safe anesthesia allowing open heart surgery on 80 year olds as well as infants, and we can do intrauterine surgery on the unborn. And business and government and the insurance companies plan to tell us what to do with all this.

On St. Patrick's Day I was called to the emergency room to care for a 19-year-old girl who was shot in the center of her upper sternum by her husband. When I arrived she was pale, gasping, in shock and intubated. A brief period of resuscitation preceded a trip to the operating room where we discovered a minor turn to the left had caused the bullet to avoid the aorta, left subclavian artery, pulmonary artery and vein. Part of her upper lobe including the bullet tract was removed quickly and the bullet wounds debrided. Twelve hours post-op this young lady sat up in bed, munching ice chips, and said "thank you for saving my life." I say to you tonight that the thrill of that moment exceeds the Super Bowl, the Kentucky Derby, the World Series, and the Final Four and is almost as good as a Hole-in-One.

Three years ago my partner and I operated on a patient involved in an auto accident who developed pericardial effusion which recurred after pericardiocentesis. The patient had a laceration of the left atrium, a torn heart which began bleeding after the pericardial sac was opened. Her heart was badly bruised and sutures wouldn't hold, despite buttressing with pledgelets. I held her still heart in my hands and began cardiac massage while the anesthesiologist with four hands administered blood, fluids, drugs, and 100% oxygen. My partner repaired the laceration in the atrium. After 20 minutes of firm massage, that lifeless heart began to beat, stronger and stronger. How can you explain to an HMO, or to a businessman, or to anyone who has never had that incredible feeling of exhilaration when you succeed, or the empty, aching desolation of failure and inadequacy ineptitude as life slips through your fingers. That is the ultimate example of the doctor-patient relationship.

But it doesn't need to be so dramatic. Years ago I sutured a facial laceration near the eye of one of my sons. A big blue eye watched the whole event. When I was finished he said, "Thank you, Daddy." That's just as good.

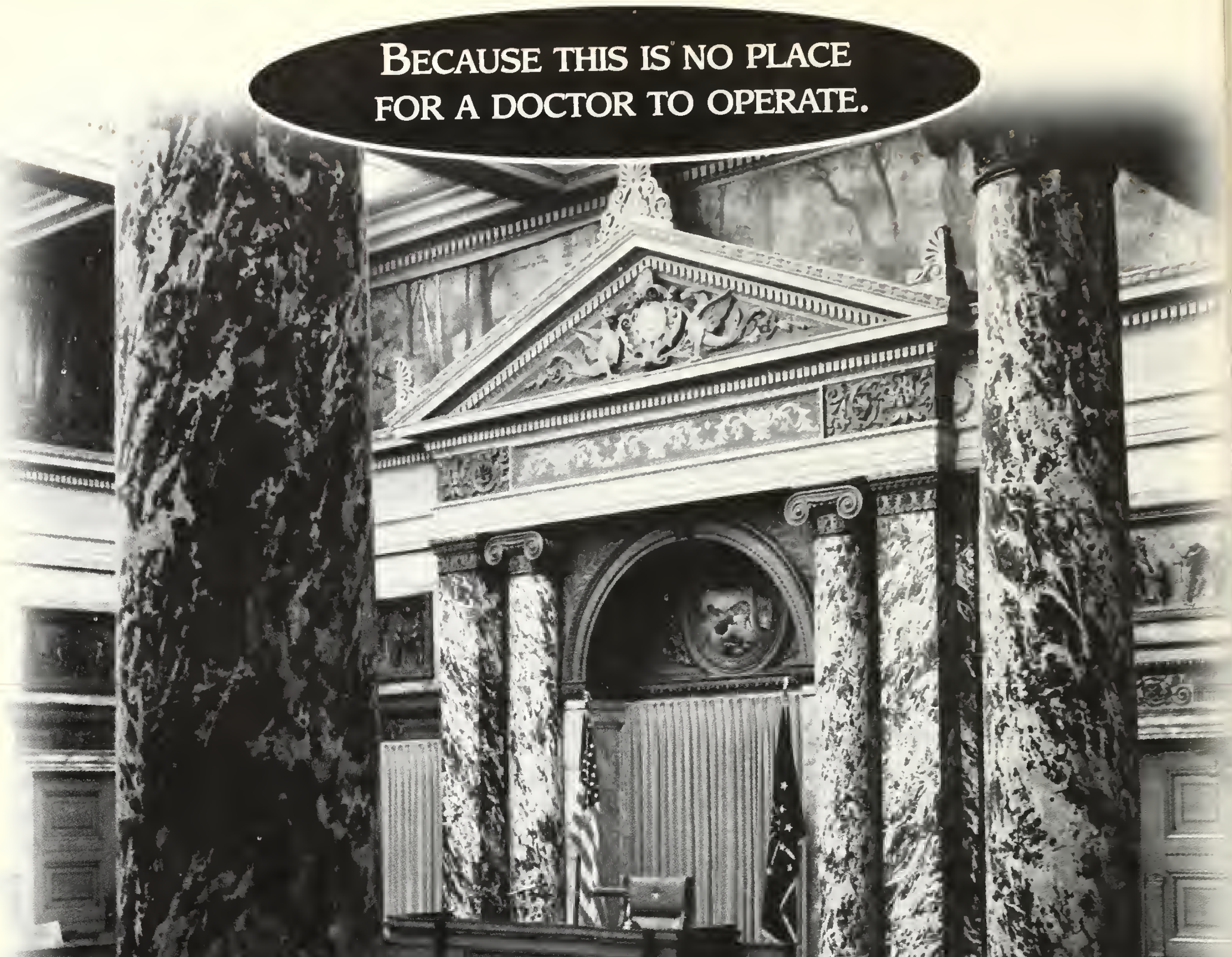
Politicians, businessmen, insurance and hospital administrators - listen up. We physicians march to a different drummer. We are motivated by things other than money.

Being a physician is a job, a profession and a calling. A calling that arises out of compassion. And what is a patient? A patient is a person who usually knows little about medicine, who is fearful of signs or symptoms of disease, and who entrusts in the physician his or her confidence, privacy, modesty, and most personal aspects of sexual, social and physical intimacy. This is a trust most people give only to their marital partners or their physician. This is a trust which is found nowhere else in humanity. This is a trust we will lose if we permit the continued erosion of the physician-patient relationship.

Let us resist the employer-employee relationship in medicine. Let us continue to be the caretakers of our patients and their families. Let us go back home as leaders of medicine and carry the word to our local medical societies, to our friends, to our fellow physicians. Let us encourage others to become involved. Let us resume our journey toward those same goals which many years ago motivated us to answer the honorable calling of physicians. Thank you very much. MoMed

1996 Recipients of the 50-Year Physician Pin

John D. Arnold, MD - ***Shawnee Mission, KS***
William C. Banton, MD - ***St. Louis***
Jack Barrow, MD - ***St. Louis***
Mac D. Bonebrake, MD - ***Springfield***
Saul Boyarsky, MD - ***St. Louis***
Robert V. Brennan, MD - ***St. Louis***
Leo A. Bruce, MD - ***Sikeston***
James E. Bumgarner, MD - ***Columbia***
Edward F. Burkhart, MD - ***Delray Beach, FL***
Alvin R. Cain, MD - ***Lamar***
John W. Cashman, MD - ***Shawnee Mission, KS***
Thomas J. Cooper, MD - ***Farmington***
Joseph P. Costello, MD - ***Chesterfield***
Katherine J. Crawford, MD - ***Carrollton***
Donald R. Davis, MD - ***Prairie Village, KS***
Roland P. Ernst, MD - ***St. Louis***
Purificacion T. Florendo, MD - ***Hannibal***
Robert E. Funsch, MD - ***St. Louis***
August J. Furla, MD - ***St. Louis***
Salvador R. Hernandez, MD - ***St. Louis***
Allen P. Klippel, MD - ***St. Louis***
George K. Landis, MD - ***Raymore***
William E. Larsen, MD - ***Shawnee Mission, KS***
Joseph M. Lichtor, MD - ***Kansas City***
Howard E. Linville, MD - ***Shawnee Mission, KS***
Lynn O. Litton, MD - ***Boca Raton, FL***
Lyle D. Litton, MD - ***Boca Raton, FL***
John R. Loughead, MD - ***Poplar Bluff***
Thomas A. Lovinggood, MD - ***Cape Girardeau***
Andrew M. Luh, MD - ***St. Louis***
Harold H. Lurie, MD - ***Springfield***
Otakar Machek, MD - ***St. Louis***
Dean C. Monroe, MD - ***Columbia***
Charles H. Nicolai, MD - ***St. Louis***
George J. Niedermeyer, MD - ***St. Louis***
James F. O'Malley, MD - ***Leawood, KS***
Lawrence W. O'Neal, MD - ***St. Louis***
Robert H. Owens - ***Shawnee Mission, KS***
Edwin M. Powell, MD - ***Springfield***
Erich A. Quer, MD - ***La Quinta, CA***
Robert C. Richert, MD - ***Kansas City***
Ned D. Rodes, MD - ***Mexico***
William L. Seabaugh, MD - ***Cape Girardeau***
John B. Shapleigh, MD - ***Chesterfield***
Alexander Shifrin, MD - ***Kansas City***
Milton Shoss, MD - ***Hilton Head Island, SC***
James C. Sisk, MD - ***St. Louis***
Richard G. Sisson, MD - ***St. Louis***
Raymond W. Stockton, MD - ***Shawnee Mission, KS***
Ernest D. Szabados, MD - ***Independence***
William C. Van Buskirk, MD - ***Shawnee Mission, KS***
Harold W. Voth, MD - ***Shawnee Mission, KS***
Stanley M. Wald, MD - ***St. Louis***
Ambrose T. Walker, MD - ***Springfield***
Byron E. Watts, MD - ***Jefferson City***
Thomas J. Weiler, MD - ***St. Louis***
Christo A. Weltscheff, MD - ***Lincoln***
Joseph C. Williams, MD - ***Shawnee Mission, KS***
George L. Williamson, MD - ***Phoenix***
Samuel C. Wittmer, MD - ***Springfield***
Joe A. Zimmerman, MD - ***Kennett***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Radiology Quiz #4

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

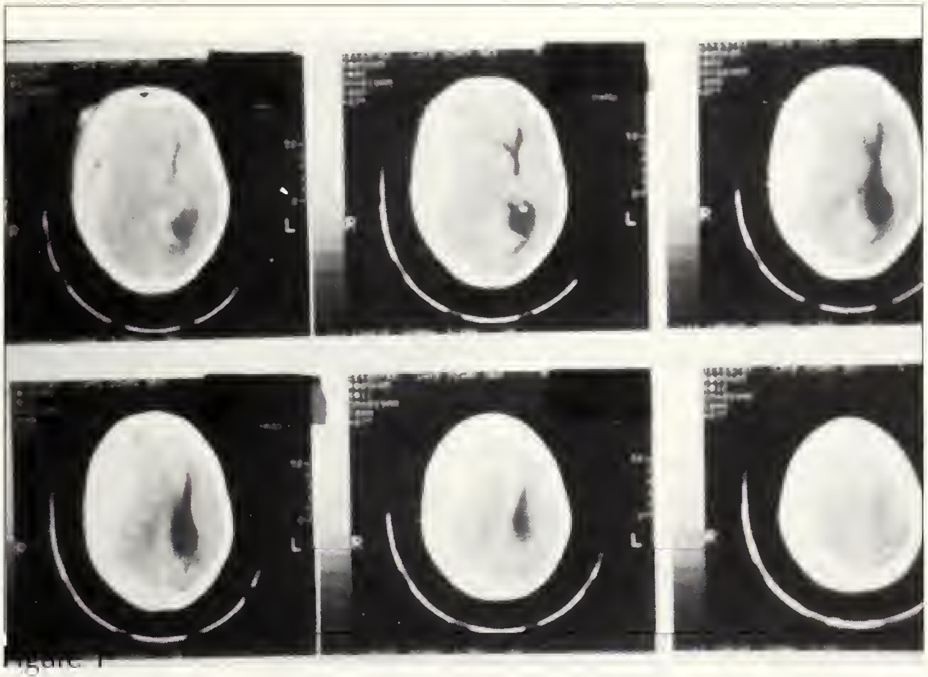

Figure 1

A 83-year-old woman was brought to the emergency room after being found comatose by her family 24 hours after a fall. A C.T. scan of the head (Fig 1) was performed.

What is the diagnosis?

- **a. subarachnoid hemorrhage**
- **b. epidural hematoma**
- **c. subdural hematoma**
- **d. hypertensive hemorrhage**

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

ANSWER: c. Subdural hematoma.

The C.T. scan shows a high attenuation fluid collection between the skull and right cerebral convexity (arrowheads) consistent with recent hemorrhage. The crescent shaped configuration would localize the collection to the subdural space. There is also marked mass effect with leftward shift of the septum pellucidum (arrow), as well as transfalcine and transtentorial herniation.

Option a) subarachnoid hemorrhage is incorrect, since no blood density is seen the subarachnoid space. On C.T., this would present as high density fluid in basilar cisterns, such as suprasellar cistern, ambient cistern, quadrageminal cistern and sylvian fissure. Contrast enhanced C.T. scanning is usually then done to look for aneurysm or AVM. The C.T. may not show 10-15% of subarachnoid hemorrhages.

Option b) epidural hematoma is unlikely due to the shape of the hematoma. Epidural fluid collections strip away dura from the inner table of the skull, resulting in a lens or biconvex shape. Epidural hematomas, unlikely subdural, may cross the midline since they are outside the falx. Epidural hematomas are often associated with trauma, especially skull fracture with disruption of meningeal vessels.

Option d) hypertensive hemorrhage is incorrect due to the location of the hemorrhage. Spontaneous hemorrhages in patients with hypertension usually occur in the basal ganglia, internal capsule and thalamus due to rupture of the lenticulostriate and thalamostriate arteries. They also may occur in the cerebellum.

References

1. Haaga JR et al Ed. *Computed Tomography and Magnetic Resonance Imaging of the Whole Body*. 3rd Edition, Mosby 1994, pp 140-159.
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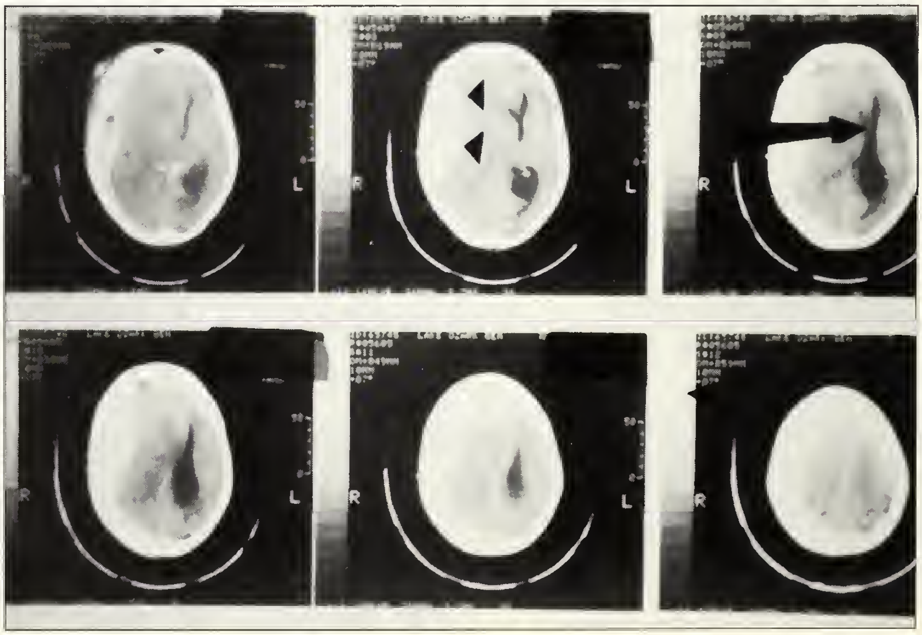

Repeat Figure 1

Membership Notes

James G. Blythe, MD, FACS, FACOG, presently Interim Chair, Department of Obstetrics and Gynecology at St. John's Mercy Medical Center, St. Louis, was installed as President of the Society of Gynecologic Surgeons (SGS) at the society's annual meeting and scientific affairs sessions in Albuquerque, NM. Dr. Blythe's term of office runs through February 1997. He is the 15th SGS President, and the first from Missouri.

Dennis W. Choi, MD, PhD, professor and head, Department of Neurology, Washington University School of Medicine, was named as one of five members to the National Advisory Neurological Disorders and Stroke Council, the major advisory panel of the National Institute of Neurological Disorders and Stroke. Donna E. Shalala, Secretary of the U.S. Department of Health and Human Services recently announced the appointments. The Council meets three times a year to review applications from scientists seeking financial support for biomedical research and research training on disorders of the brain and nervous system. Members also advise the institute on research program planning and priorities.

Dr. Choi, an award-winning neurobiologist, is known for his work on the role of glutamate in neuronal injury. He holds advisory and leadership positions with a number of professional and lay organizations, and serves on the editorial boards for several scientific journals.

David M. Kipnis, MD, Distinguished University Professor of Medicine and professor of molecular biology and pharmacology at Washington University School of Medicine in St. Louis, has been elected to a three-year term on the Council of the National Academy of Sciences. The Academy is a private organization of scientists and engineers dedicated to furthering science and its use to benefit the public. The Council serves as its board of directors. Dr. Kipnis was elected to the organization in 1984. He is internationally renowned as a pioneer in diabetes research, focusing on the mechanisms of sugar and amino acid transport and regulation of insulin release by islet cells in the pancreas. His work has been cited for many honors, including the Endocrine Society's Ernest Oppenheimer Award and the American Diabetes Association's Lilly Award and Banging Medal.

Dr. Kipnis came to Washington University in 1955 as an American College of Physicians Research Fellow to study under Nobel laureate Carl F. Cori, MD. He was head of Department of Internal Medicine from 1973 to 19992. The department became recognized nationally and internationally as one of the foremost academic centers for research and clinical training. He also played a major role in establishing the Washington University/Monsanto Biomedical Research agreement - the largest research collaboration between and American company and an American university, which he still directs.

Jay F. Piccirillo, MD, assistant professor of otolaryngology at Washington University, received a two-year grant from the National Institute of Diabetes and Digestive and Kidney Diseases for a research project titled, "Intestinal Protein Metabolism and Function."

Daniel L. Silbergeld, MD, assistant professor of anatomy & neurobiology and neurology & neurological surgery, received a five-year grant from the National Cancer Institute for a research project titled "Astrocytoma Motility and Invasion."

Michael W. Vannier, MD, professor of radiology and assistant professor of surgery at Washington University, received a five-year grant from the National Institute of Neurological Disorders and Stroke for a research project titled, "Normal MR Neuromorphometry by Global Pattern Matching."

Teresa J. Vietti, MD, professor of pediatrics and radiology at Washington University, received a five-year grant from the National Cancer Institute for a research project titled "Pediatric Oncology Group."

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine****, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

New Members

Audrain

Riaz H. Shah, MD - IM
809 Medical Park Dr. #104
Mexico, MO 65265
Khyber Med College, Pakistan; 1987

Boone

Kyung M. Noh, MD - R
1502 E. Broadway
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University of Rochester, NY; 1988

Harold A. Williamson, MD - FP
MA303 Hlth Sci Ctr
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Case Western Reserve; 1976

Clay-Platte

James P. Reardon, MD - ORS
2750 Clay Edwards Dr. #304
N. Kansas City, MO 64116
University of Missouri-KC; 1988

Kent E. Tegeler, MD - OBG
28 Westwoods Dr., Liberty, MO 64068
University of Missouri-Columbia; 1979

Dana R. Towle, MD - PS
5400 N. Oak Trafficway #105
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St. Louis University; 1986

Franklin-Gasconade-Warren

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800 East Fifth St. #202
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Loyola University; 1989

Greene

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1443 N. Robberson Ste 701
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University of Missouri-Columbia; 1989

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UCLA School of Med, CA; 1981

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University of Oklahoma; 1990

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Springfield, MO 65807
Tulane University; 1978

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Kirksville Coll Osteo Med; 1987

Johnson

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University of Missouri-Columbia; 1973

Metro Med of K.C.

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University of Missouri-KC; 1987

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University of Missouri-KC; 1991

Walter J. Ricci, MD - EM
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University of Missouri-KC; 1991

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6150 Oakland Ave, St. Louis, MO 63139
Louisiana State University; 1989

James M. Hartman, MD - OTO
4932 Forest Park 6-A
St. Louis, MO 63108
University of Missouri-KC; 1988

Joseph R. Huguenard, MD - FP
1832 Chestnut St, St. Louis, MO 63103
University of Michigan; 1973

Raana J. Ponstingl, MD - IM
10010 Kennerly Rd.
St. Louis, MO 63128
Pahlavi University, Iran; 1978

William O. Shaffer, MD - ORS
3635 Vista at Grand Blvd.
St. Louis, MO 63110
University of Michigan; 1976

F. Duane Turpin, DO - N
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Bridgeton, MO 63044
Oklahoma State University
Coll of Osteo Med,Tulsa; 1991

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Amy S. Brumfield, MD - IM
Thomas W. Frederickson, MD - IM
Jeffrey L. Genzlinger, MD - IM
Robert R. MacDonald III, MD - OTO
Mohammad K. Pourakbar, DO - IM

Students

University of Missouri-KC

Sai H. Chavala
Michael J. Giocondo

Washington University

Hillary D. Johnson

In Memoriam

Burleigh DeTar Sr., MD, 97, Joplin, Missouri, died March 23, 1996. Dr. DeTar received his medical degree the University of Kansas in 1924. He served in the Army medical corps during World War I. Dr. DeTar practiced medicine more than 50 years in Joplin and retired in 1984. He was a member of the American Medical Association, Jasper County Medical Society, International College of Surgeons, American Society of Abdominal Surgeons and The Southwestern Surgical Congress.

Charles R. Doyle, MD, 90, Richmond Heights, Missouri, died March 25, 1996. Dr. Doyle received his medical degree at the University of Michigan, Ann Arbor, in 1931. He was in private practice in St. Louis for more than 36 years before he retired in 1981. Dr. Doyle was a general and vascular surgeon. He was a former chief of surgery at St. John's Mercy Medical Center in Creve Coeur, the old St. Louis County Hospital in Clayton and St. Mary's Health Center in Richmond Heights, which honored him in 1985 for his years of service. Dr. Doyle was on the staffs of St. Louis University Hospital and Cardinal Glennon Children's Hospital. From 1969 to 1975, he was an adviser on the council to the president of St. Louis University. He was an emeritus professor of clinical surgery at the university's school of medicine. For 25 years, he was a volunteer physician for the football team at St. Louis University High School. Dr. Doyle was a past officer of the St. Louis Medical Society, St. Louis Surgical Society and the Missouri State Medical Association, and a member of the American College of Surgeons.

Farid M. Fuleihan, MD, 60, Creve Coeur, Missouri, died March 23, 1996, from a heart attack. Dr. Fuleihan received his medical degree at the American University, Beirut, in 1961. He came to St. Louis in 1963 and taught urology at Washington University School of Medicine for five years. Dr. Fuleihan was a former chief of urology at St. John's Mercy Medical Center. He headed St. John's urology department from 1971 until the early 1980s and remained on staff while maintaining a private practice in the St. John's Doctors Building. He also was on the staff of St. Joseph Hospital in Kirkwood.

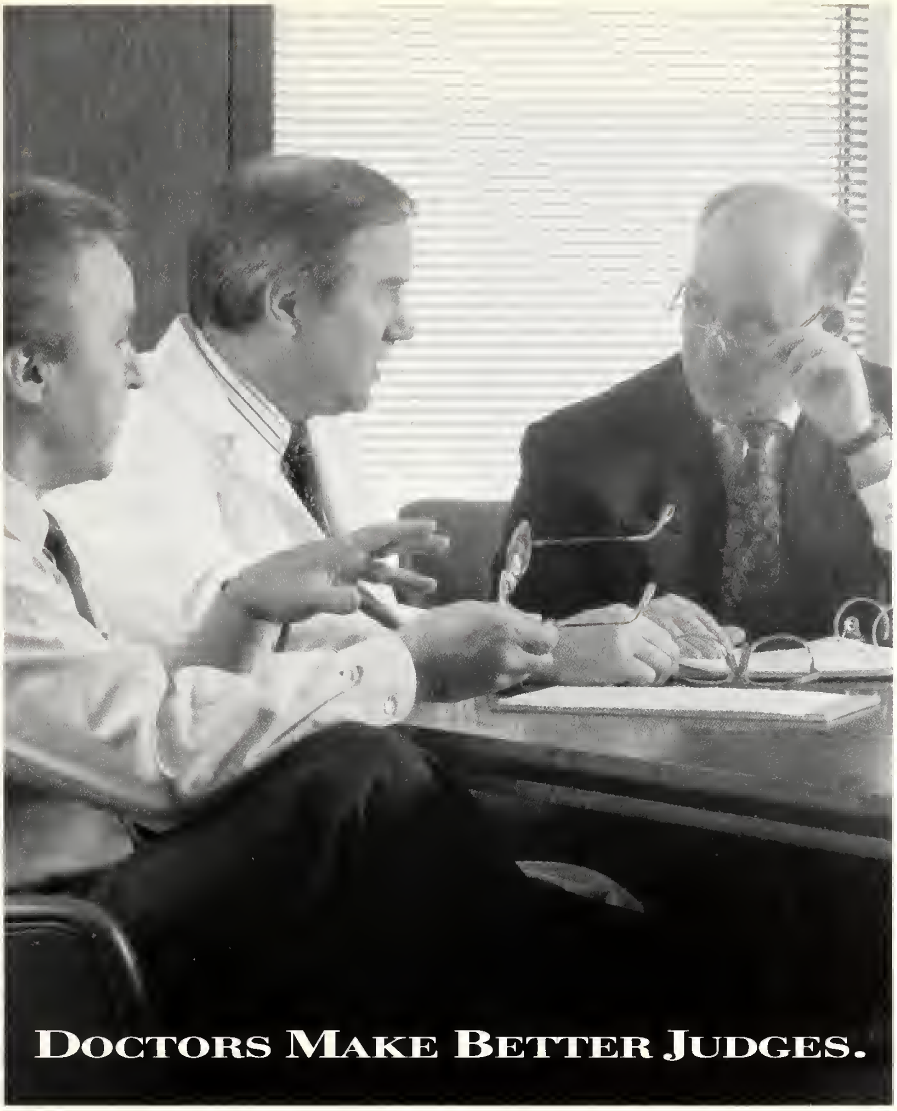
Robert G. Hughes, MD, 73, Creve Coeur, Missouri, died March 25, 1996. Dr. Hughes received his medical degree at St. Louis University in 1948, where he had been an instructor of internal medicine since 1985. Dr. Hughes was affiliated with the department of behavioral medicine at St. Louis University since 1984. Before that, he was a family practitioner in Creve Coeur. He also worked at the St. Louis Behavioral Medicine Institute. He retired in January. Dr. Hughes served on the staffs of St. Mary's Health Center in Richmond Heights, St. John's Mercy Medical Center in Creve Coeur, DePaul Health Center in Bridgeton and St. Louis University Hospital. He was a member of the American Academy of Family Physicians and the American Occupational Medical Association.

Donald L. Twedell, MD, 89, Chesterfield, Missouri, died April 19, 1996. Dr. Twedell received his medical degree at St. Louis University in 1931. He was a general surgeon on staff at St. John's Mercy Medical Center in Creve Coeur and Christian Hospital Northeast in north St. Louis County for 40 years. He retired in 1971. Dr. Twedell also taught courses on experimental surgery for many years at St. Louis University School of Medicine. He was a contributor and fund-raiser for both the medical center and the school of medicine. In 1956, he helped found the Charles the First Medical Center, an extended health care facility in St. Louis for older adults with terminal illnesses. His family owned and operated the facility until selling it in 1992. Dr. Twedell was a member of the American Abdominal Surgeons and the American Occupational Medical Association.

In Memoriam

The following MSMA members were recognized with a moment of silence by the House of Delegates during the 138th Annual Convention:

Robert Adams, *Joplin* - died 11/7/95
Louis Aitken, *St. Louis* - died 1/25/96
Edward Auer, *Philadelphia, PA* - died 1/23/95
Keith Averill, *Mission Hills, KS* - died 12/02/95
Colita Banez, *St. Louis* - died 2/19/96
Mark Bauman, *Poplar Bluff* - died 3/31/95
Grace Bergner, *St. Louis* - died 10/02/95
George Blankenship, *Neosho* - died 7/29/95
Edward Bowdern, *St Louis* - died 7/04/95
Harold Bowerman, *St. Louis* - died 4/09/95
George Boyd, *Shawnee Mission, KS* - died 10/29/95
Robert Bristow, *St. Joseph* - died 12/02/95
John Brooks, *Rogersville* - died 12/04/95
Adrian Brown, *Kansas City* - died 8/20/95
Sydney Bryant, *Baton Rouge, LA* - died 5/28/95
Robert Burns, *Sonoma, CA* - died 11/08/95
John Caldwell, *Kansas City* - died 11/28/95
Arsenio Canlas, *Bridgeton* - died 12/18/95
Hjalmar Carlson, *Overland Park, KS* - died 2/05/96
Raymond Conrad, *Springfield* - died 1/20/96
Arthur Dalton, *St. Louis* - died 1/24/96
Richard Danis, *St. Louis* - died 1/30/96
Burleigh DeTar, *Joplin* - died 3/25/96
Luke Dlabal, *Independence* - died 2/25/96
Charles Doyle, *St Louis* - died 3/25/96
Williamm Dreyer, *Houston* - died 5/13/95
Oliver Duffy, *Trenton* - died 12/08/95
Robert Duncan, *Springfield* - died 8/29/95
Wallace English, *Senath* - died 4/26/95
Jackson Eto, *St. Louis* - died 1/24/96
Gerhard Flegel, *Florissant* - died 11/01/95
Alvin Frank, *St Louis* - died 12/03/95
Farid Fuleihan, *St. Louis* - died 3/23/96
Kenneth Glover, *Mount Vernon* - died 4/09/95
Alvin Goldfarb, *St. Louis* - died 3/30/95
Daniel Gould, *St. Louis* - died 12/23/95
Wallace Graham, *Kansas City* - died 1/04/96
Olin Griffin, *Springfield* - died 9/04/95
Fleming Harper, *St. Louis* - died 5/11/95
George Hawkins, *St. Louis* - died 4/06/95
Paul Hayes, *St. Joseph* - died 11/27/95
H. Hengen, *Bridgeton* - died 3/03/96
Chester Hill, *Alton, IL* - died 10/17/95
Frederick Hink, *Independence* - died 2/08/96
Frank Hodgson, *Overland Park, KS* - died 8/25/95
Thomas Hopkins, *Sedalia* - died 4/19/95
Robert Hughes, *St. Louis* - died 3/25/96
Charles Jacobs, *Grover* - died 5/07/95
John James, *St. James* - died 2/10/96
Richard Johnson, *Columbia* - died 6/16/95
Keith Jones, *Warrensburg* - died 1/21/96
Alex Kaplan, *St. Louis* - died 2/19/96
R. Kelly, *St Louis* - died 8/23/95
Theodore Kiekhaefer, *St. Joseph* - died 4/07/95
Franklin Knight, *St. Charles* - died 1/18/96
Lawrence Kotner, *St. Louis* - died 5/21/95
Randall Kuntze, *Kennett* - died 11/14/95
Clark Lentz, *Prairie Village, KS* - died 5/25/95
William Leo, *Kansas City* - died 11/17/95
Patrick Little, *Hayti* - died 4/20/95
Charles Lockhart, *Springfield* - died 10/06/95
Ellen Loeffel, *St. Louis* - died 8/15/95
Frank Long, *Chesterfield* - died 2/18/96
Harold Lyddon, *Kansas City* - died 11/29/95
Albert May, *Poplar Bluff* - died 12/07/95
Mary McCaffree, *Jefferson City* - died 10/18/95
Wilbur McDonald, *St. Joseph* - died 9/15/95
John Michaelree, *St. Louis* - died 10/07/95
Clyde Milster, *St Louis* - died 10/24/95
De Armond Moore, *Springfield* - died 8/05/95
Hugh Mosbacher, *Lee's Summit* - died 4/29/95
John Mothershead, *St. Joseph* - died 10/17/95
William Parker, *St. Louis* - died 10/06/95
Roy Petrie, *St. Louis* - died 5/17/95
Mauricio Pimentel, *St Louis* - died 11/26/95
Beaumanoir Prophete, *St Louis* - died 2/20/96
Harry Purcell, *St. Louis* - died 10/13/95
Maxwell Rachlin, *Ellington, CT* - died 2/27/96
Lowell Riller, *Kansas City* - died 9/04/95
John Roberts, *St. Louis* - died 1/27/96
Melvin Roblee, *Richmond, VA* - died 9/28/95
Melvin Rubenstein, *St. Louis* - died 8/11/95
Leon Rubnitz, *Kansas City* - died 5/22/95
Theodore Sanders, *Ballwin* - died 9/07/95
William Slentz, *Overland Park, KS* - died 5/29/95
Garland Smith, *St. Louis* - died 7/28/95
J. Ned Smith, *Columbia* - died 2/18/96
Walter Stewart, *Columbia* - died 4/05/95
Eamil Stricker, *St. James* - died 7/18/95
Robert Sweet, *Springfield* - died 9/26/95
Liep Tio, *West Plains* - died 9/30/95
Robert Treiman, *St. Louis* - died 9/26/95
Barnard Trowbridge, *Prairie Village, KS* - died 7/19/95
Don Weir, *St. Louis* - died 9/20/95
Barry White, *Puxico* - died 4/13/95
John Williams, *Kansas City* - died 5/12/95
Walter Williamson, *Midland, TX* - died 3/26/95
Bernard Winston, *Kansas City* - died 2/05/96
Joe Zimmerman, *Kennett* - died 12/26/95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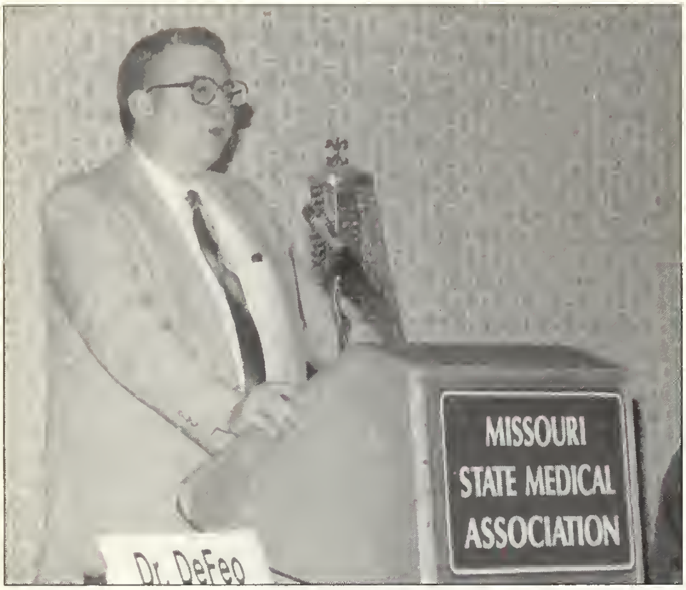
Minutes of the House of Delegates



Speaker of the House of Delegates Frederick DeFeo, MD, calls the 138th MSMA Annual Convention to order.

FIRST SESSION

The first session of the MSMA House of Delegates was called to order at 10 a.m., Thursday, April 11, 1996 by Speaker of the House Frederick DeFeo, MD. The following officers and delegates were present at the 138th Annual Convention:

Officers

President	Frederick W. Hahn, MD
President-elect	Daniel F. O'Sullivan, MD
Immediate Past President	H. Jerry Murrell, MD
Vice President	Howard H. Braby, MD
Vice President	John Anstey, MD
Vice President	Paul Anderson, MD
Secretary	Norman P. Knowlton, III, MD
Treasurer	David Wilkinson, MD
Speaker	Frederick G. DeFeo, MD
Vice Speaker	John L. Rollo, MD

Councilors

District 1
Stephen Vilmer, MD
District 2
Carl R. Kruse, MD
District 3
Gordon M. Goldman, MD
Robert N. Miller, MD
Arturo Montes, MD
Meredith Payne, MD
Newton B. White, MD
District 4
Sammy L. Farrell, MD
District 5
Jerry D. Kennett, MD
Robert P. Wankum, MD
District 6
A. J. Campbell, MD, *Chair*
District 7
William E. Dorzab, MD
Linda Dorzab, MD
Lawrence A. Rues, MD
Robert T. Gibbons Jr., MD
District 8
Duane Hellam, MD
Clarence A. Martin, MD
District 9
David Barbe, MD
District 10
William C. Shell, MD

Hospital Medical Staff
Charles Barbee, MD
Student Section
Dawn Kleindorfer

Vice Councilors

District 1
Robert Schaaf, MD
District 2
Lent Johnson, MD
District 3
Robert E. Treadwell, MD
District 4
Jeffrey G. Copeland, MD
District 5
Joseph A. Corrado, MD
District 6
Jerry Meyer, MD
District 7
Deborah A. Jantsch, MD
District 8
James B. Wolfe, MD
District 9
Edward R. Jenkins, MD
District 10
Mark C. Kasten, MD
Organized Medical Staff
Luis Anglo, MD
Medical Student Section
Nancy Poggi

AMA Delegates

H. Peter Ekern, MD
Robert Gibbons, Jr., MD
William Huffaker, MD
Jack Kayes, MD
Jo-Ellyn Ryall, MD
Hugh Stephenson, MD

AMA Alternate Delegates

David Barbe, MD
Jonathan Dehner, MD
Arthur Gale, MD
H. Jerry Murrell, MD
Carl Strauss, MD
Robert Puchalski

House of Delegates

District 1
Buchanan
Merlin Brown, MD
Bonnie Lee Birchansky, MD
James Conant, MD
Robert Lackamp, MD
B. A. Moranville, II, MD
Robert Schaaf, MD
Clay-Platte
Donald Fakhoury, MD
Kathryn Hembree, MD
Stephen McCray, MD
James Stewart, MD
Frederick Thompson, MD
Grand River
John Dixon, MD

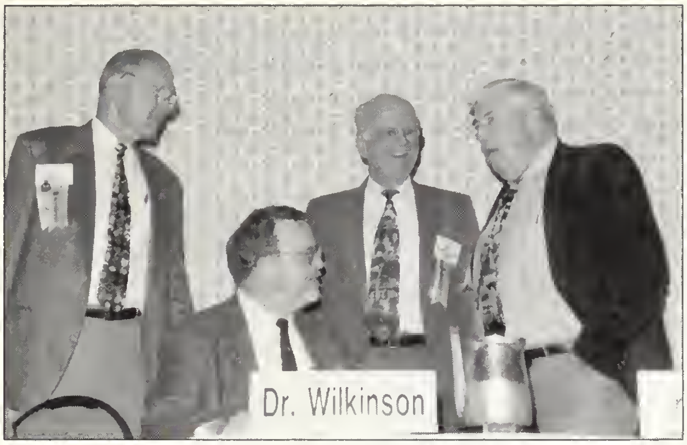
District 2
Northeast
Sandra Ahlum, MD
Josel Hassien, MD
Brett Hosley, MD

District 3
St. Louis Metropolitan
Luis Anglo, MD
John Anstey, MD
Donald Arnold, MD
Vernon Balster, MD
George Bohigian, MD
Edmond Cabbabe, MD
Christine Cernik, MD
Octavio Chirino, MD
Jeffrey Craver, MD
Jonathan Dehner, MD
Arthur Gale, MD
James Gibbons, MD
Richard Gimpelson, MD
John Gladney, MD
Mary Grimm, MD
William Huffaker, MD
Jack Kayes, MD
John Kellett, MD

John Laird, MD
Lynda Laposky, MD
Herluf Lund, Jr., MD
K. Lynne Moritz, MD
Charles Norland, MD
Edward O'Brien, Jr., MD
Henry Onken, MD
Daniel O'Sullivan, MD
David Perkins, MD
Samuel Ramirez, MD
Robert Ramsey, MD
James Redington, MD
Susan Reynolds, MD
Gregory Rinehart, MD
Jo-Ellyn Ryall, MD
Joseph Simpson, MD
Earl Smith, III, MD
J. Regan Thomas, MD
William Totty, MD
Randall Treadwell, MD
Harvey Walker, Jr., MD
Bruce Walz, MD
Joseph West, MD
Martin Wice, MD
David Wilkinson, MD
Carol Williams, MD
J. Michael Zylka, MD

District 4
St. Charles-Lincoln
Robert Kinsbury, MD

District 5
Audrain
Glenn Gordon, MD
Casey Rogers, MD
Boone
Edgar Ailor, MD
Susan Ailor, MD
William Allen, MD
Murray Boles, MD
William Crowley, Jr., MD
Diane Brukardt, MD
Mila Cunningham, MD
John DeSpain, MD
Ted Groshong, MD
Lenard Politte, MD
Kenneth Rall, MD
Steven Standiford, MD
Hugh Stephenson, MD
Mark Vandewalker, MD



President-elect Daniel O'Sullivan, MD shares a joke with Council Chair A. J. Campbell, MD, Treasurer David Wilkinson, MD, and President Fred Hahn, MD.

Cole
James Allan, MD
George Carr, MD
Curtis Cox, MD
Rebecca Lueckenhoff, MD
Lake of the Ozarks
Richard Heimberger, MD
George Hubbell, MD
Carl Petit, MD

District 6
Lafayette-Ray
Jerry Meyer, MD
Pettis
Phillip Hornbostel, MD
West Central
Bill Haynie, MD
Gerald Lee, MD
Warren Lovinger, MD
Glen Reed, MD
Bill Turner, MD

District 7
Metro Med of K. C.
Thomas Allen, MD
Barbara Buchanan, MD
Steven Buie, MD
Richard Butin, MD
Michael Caughron, MD
G. David Dixon, MD
Thomas Fritzlen, MD
Richard Gutknecht, MD
Deborah Jantsch, MD
Pierre Keitges, MD
Gregg Laiben, MD
Loretta Loftus, MD
Alexander Mallouk, MD
John Mitchell, MD
Carl Myers, MD
Donald Potts, MD
Wade Robinett, MD
Larry Rues, MD
Jay Yedlin, MD

District 8
Barton
Alvin Cain, MD
Greene
James Blaine, MD
Mike Clarke, MD
Karel deLeeuw, MD
Darrel Domann, MD
Michael Gentry, MD
Leon Gregston, MD
Charles H'Doubler, MD
Michael Hoeman, MD
Roy Holand, MD
Norman Knowlton, III, MD
Keith LaFerriere, MD
Hal Lurie, MD
Stanley Peterson, MD
Arteso Raborar, MD
James Rogers, MD
Joni Scott, MD
William Taylor, MD
Norman Wall, MD
Arlen Winsky, MD
Robert Zahn, MD
Jasper-Newton
Robert Betz, MD
Howard Meridy, MD
Thomas Moore, MD
Joe Newman, MD
Ira Joe Pryor, MD
W. Dale Rankin, MD
Duane Sherrod, MD
Ozarks
William Hamilton, MD
Richard Betz, MD
Webster
T. M. Macdonnell, MD

District 9
Mid-Missouri
Ed Jenkins, MD

Continued on page 218

Over $43,000 from exhibitors and contributing companies went towards the cost of the Annual Convention. A complete listing of the supporters appears on page 241.

Community Service Awards Recognize Three Johns

John Anstey, MD, is currently in private practice in St. Ann, on the teaching faculty at St. John's Mercy Medical Center, and is chief of OB-GYN department at the Missouri Baptist Medical Center. As president and past president of St. Louis Metropolitan Medical Society, Dr. Anstey has focused on community service projects and preventive medical programs. In 1994, "Physicians Caring for the Community" – a program was started to address several health problems in St. Louis. Because of Dr. Anstey's efforts, private, public and governmental groups came together to attempt to immunize 10,000 children in areas with low immunization rates. He was also instrumental in developing an area-wide food drive, which resulted in a collection of more than 16,000 pounds of food for distribution by Operation Food Search to area food pantries. Dr. Anstey also focused on developing a teen pregnancy prevention program for St. Louis. Grant money was raised from area businesses and organizations, and created and implemented an area-wide awareness campaign featuring the message through local media. Dr. Anstey introduced "Postponing Sexual Involvement" to an area school district with support services provided by the St. Louis County Health Department. He also helped develop a program with the SLMMS Alliance to produce and distribute more than 90,000 informational brochures about dating violence and abuse among teenagers.

C. John Ritter, MD, has been serving Cape Girardeau since 1969 when he returned from the U.S. Army to practice internal medicine. He is actively involved in the Cape Girardeau Community Caring Council, an organization of school, civic, and religion leaders who work through school-linked and school-based service activities, particularly working with underprivileged children and their families. He is also involved in international relief efforts and joined Doctors of the World, traveling to the small island community of Barbuda in 1994 for one month and returning to the area in 1995 to assist with hurricane relief efforts. Dr. Ritter is an active church leader, member of the Chamber of Commerce, and has been a member of the Public School Board of Education for a number of years. He has served as vice president and president for the Cape Girardeau Doctors' Park medical group. He has held staff positions at Southeast Missouri Hospital and at the St. Francois Medical Center. He is a member with certified experience at the Chemical Dependency Unit at St. Francois.

John Ferguson, MD, has been practicing obstetrics and gynecology in Springfield for 46 years. In 1989 he started participating in the Sexual Assault Forensic Exam or SAFE Network. Dr. Ferguson has examined more than 600 possibly sexually abused female children. He accepted this demanding position while in active practice and has generously continued in the program since his retirement. His colleagues say that he has been successful in this program because he is a physician with the personality qualities and the demeanor necessary to gain the trust of children and young teenagers, who by their experiences frequently fear and distrust everyone. In addition to his dedication to the SAFE Network, Dr. Ferguson has committed himself to his practice of obstetrics and gynecology at the Women's Clinic in Springfield, St. John's Regional Health Center, and the Lester E. Cox Medical Center. He is a past president of the Greene County Medical Society.

Continued from page 217

District 10
Buter-Wayne-Ripley-Carter
Gene Leroux, MD
Ann Peick, MD
Cape Girardeau Area
D. Curtis Coonce, MD
Theodore Glenn, MD
Mark Kasten, MD
Richard Martin, MD
C. John Ritter, MD
Stan Sides, MD
Thomas Sparkman, MD
Dunklin
Nicholas Robinson, MD
Jefferson
Alfred Shaplin, MD
Minderal Area
J. David Auner, MD
Perry-Ste. Genevieve
Job Pontillas, MD
SEMO
Fred Thornton, MD

Delegates-at-Large
Lester Bryant, MD
Richard Bradley, MD
Frederick DeFeo, MD
Gary Dyer, MD
H. Peter Ekern, MD
Melvin Kasten, MD
John Matthews, MD
Andrew McCanse, MD
H. Jerry Murrell, MD
John Rollo, MD

Resident Physicians Section
Mary Contogiannis, MD

Medical Students Section
University of Missouri-KC
Vasu Kakarlapudi
St. Louis University
Michelle Eason
Nancy Poggi
University of Mo-Columbia
Jason Burns
Rich Sipes
Washington University
Allen Kachalia
John Madden

The First Session of the 138th House of Delegates began at 10 a.m., Thursday, April 11, 1996, with the official call to order by Speaker of the House Frederick DeFeo, MD. President Frederick Hahn, MD, gave welcoming remarks.

Stanley Peterson, MD, gave report of the Committee on Credentials: 9 Officers, 29 Councilors and Vice Councilors, and, 83 Delegates were in attendance. This report and the minutes of the 137th Annual Convention as published in May 1995 *Missouri Medicine* were approved.

Speaker DeFeo announced the members of the reference committees as follows: *Reference Committee A*: Jonathan Dehner, MD, chair; Steve Buie, MD, Ed Ailor, MD, Michael Hoeman, MD, and Ann Peick, MD. *Reference Committee B*: Ted Groshong, MD, chair, Jim Rogers, MD, Richard Gimpelson, MD, Bill Haynie, MD and Stephen McCray, MD.

MSMA President Frederick Hahn, MD, addressed the House. His remarks appear on page 200 of this issue. President-elect Daniel O'Sullivan, MD, briefly addressed the House.

MSMA Alliance President Mrs. Nona Nan Chapman reported the Alliance activities for this past year. Her remarks appear on page 239.

Dr. Hahn then presented the Citizenship and Community Service Awards to John Anstey, MD, of St. Louis; C. John Ritter, MD, of Cape Girardeau; and, John Ferguson, MD, of Springfield.

Dr. Hahn then introduced featured speaker Nancy Dickey, MD, Chair of the Board of Trustees for AMA. Dr. Dickey is a board certified family physician from Richmond, Texas. She has served as Secretary-Treasurer of the AMA, and as a member of the Board's Executive Committee. Dr. Dickey chaired the AMA's Ad Hoc Technical Advisory Committee on Health System Reform, and has served as the AMA Commissioner for Joint Commission on Accreditation. An excerpt of Dr. Dickey's address appear on pages 227-228.

Melvin Kasten, MD (left) of Cape Girardeau was recognized with a Service Award from President Fred Hahn, MD, for his many years of dedication to the MSMA.

MISSOURI
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Missouri State Senator Roseann Bentley of Springfield was recognized with an MSMA Legislative Award for her political support of issues involving medicine.

Speaker DeFeo called on James Schell, MD, to give the Missouri Patient Care Review Foundation report. Dr. Schell reported the Foundation shifted from Medicare peer review to the adoption of the principles of continuous quality improvement and total quality management, causing a reduction in individual case review to fewer than 2,500 cases this year. The MPCRF is now recognized as a innovator in the PRO/PIO community. He also recognized the other MSMA members of the Foundation Board: Turner Minnigerode, MD, Mark Leeter, MD, Arturo Montes, MD, Jim Rogers, MD, Frank Mohs, MD, Walter Davisson, MD, and Fred Peterson, MD. Dr. Peterson completed a six-year tenure on the Board of Directors of the American Medical Peer Review Association and was recently honored by that board for his service.

Richard Bradley, MD, then gave the report on MOMEDICO. He reported that MOMEDICO is exploring partnerships in Missouri and across the several states and may enter into an association with West Virginia, Ohio, Indiana, Alabama, and Texas, to enlarge the economic base. MOMEDICO is also pursuing an A-rating from Best and Company.

Continued on page 220

Continued from page 219

Dr. Hahn then appointed the following members to the Committee on Nominations:

District 1	Donald Fakhoury, MD, *Kansas City*
District 2	Ed Plowman, MD, *Hannibal*
District 3	George Bohigian, MD, *St. Louis*
District 4	Jeffrey Copeland, MD, *St. Charles*
District 5	Hugh Stephenson, MD, *Columbia*
District 6	Phillip Hornbostel, MD, *Sedalia*
District 7	Lawrence Rues, MD, Chair, *Kansas City*
District 8	Norman P. Knowlton, III, MD, *Springfield*
District 9	Edward Jenkins, MD, *Waynesville*
District 10	Tom Sparkman, MD, *Cape Girardeau*
HMSS	Peggy Barjenbruch, MD, *Mexico*
RPS	Mary Vest-Mason, MD, *St. Louis*
MSS	John Madden, *Washington University*

Dr. Hahn thanked Cork Swarens, MSMA Executive Vice-President for his first full year in office; MSMA staff, the Executive Committee, and the MSMA Council for their work throughout the year, as well as the delegates in attendance.

The House stood for a moment of silence to honor physicians who died since the last meeting. These members' names appear on page 214.

Dr. DeFeo then directed the acceptance and committee assignment of three late resolutions.

Following reminders of meetings and attention brought to the MSMA Survey of Interest in Developing a Managed Care Organization, Speader DeFeo ajourned the first session of the 138th Annual Convention.

Reference Committee A: (left to right) Michael Hoeman, MD, Chair Jonathan Dehner, MD, Steve Buie, MD, Ann Peick, MD, and Ed Ailor, MD.

SECOND SESSION

The second session of the House of Delegates was called to order by Speaker DeFeo at 4 p.m., Friday, April 12, 1996.

Dr. DeFeo then called upon Melvin Kasten, MD, to give the Supplemental Report of the Committee on Credentials. Dr. Kasten reported that the following number of members presented satisfactory credentials, constituting the roll call of the 1996 Annual Convention of the House of Delegates: 9 Officers, 30 Councilors and Vice Councilors, and 118 Delegates. The report was adopted.

Dr. Kasten was then invited to give the report on MMPAC. He stressed the importance of contributions during an election year, and that MMPAC currently had 44% of the contributions it had last year. He reminded delegates of the winning record of candidates supported by MMPAC in 1994.

Speaker DeFeo then asked Dr. Kasten to remain at the microphone. President Hahn joined Dr. Kasten to present him with the MSMA Service Award, recognizing his outstanding medical service and dedication to the medical profession and his physician colleagues.

President Hahn had Dr. Kasten remain for the next presentation, a Legislative Award given to the Honorable Representative Mary Kasten. MSMA presented Legislative Awards to three lawmakers who are married to physicians: Representative Mary Kasten from Cape Girardeau, District 158; Senator Betty Sims of St. Louis, District 24; and, Senator Roseann Bentley of Springfield, District 30.

Speaker DeFeo then called upon Larry Rues, MD. Chair of the Nominating Committee, to present the slate of officers. Dr. Rues reported the Nominating Committee appointments:

President-Elect	A. J. Campbell, MD
First Vice President	David Wilkinson, MD
Second Vice President	William Woolridge, MD
Third Vice President	Robert T. Gibbons, Jr, MD
Speaker	Frederick DeFeo, MD
Vice Speaker	John Rollo, MD
AMA Delegates	Jack Kayes, MD
Arthur Gale, MD	David Hall, MD
Jo-Ellyn Ryall, MD	Hugh Stephenson, MD
Alternate Delegates	Arthur Gale, MD
Dan O'Sullivan, MD	William Dorzab, MD
Jonathan Dehner, MD	Carl Strauss, MD

The Student Section named its AMA Delegate before the election of nominations on Sunday.

Speaker DeFeo asked for nominations from the floor. Ann Peick, MD, a delegate from the 10th District, nominated on behalf of Cape Girardeau County Area Medical

Reference Committee B: (front) Jim Rogers, MD, Richard Gimpelson, MD, Chair Ted Groshong, MD, Bill Haynie, MD and Stephen McCray, MD.

Society Dr. Mark Kasten as an AMA Alternate Delegate.

Dr. DeFeo indicated that there would be an election of officers during the Third Session, Sunday morning.

Speaker DeFeo then called for the reports of the Reference Committees. See pages 229-233 for committee and commission reports. The following actions were taken on submitted resolutions:

Reference Committee A

Jonathan Dehner, MD, of St. Louis presented the report of Reference Committee A. The following items were placed on the consent calendar:

Report of Commission on Medical Economics,
Third Party Medicine and Governmental Relations
Report of MSMA Peer Review Consultant System
Report of Missouri State Medical Services, Inc.

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution #3 "Statewide Credential Verification Service as a New Member Benefit" – St. Louis Metropolitan Medical Society ***Substitute Resolution Adopted***

RESOLVED, that the Missouri State Medical Association, in conjunction with component medical societies, offer a member benefit of a credential verification service that meets all of the standards established by the JACHO and the NCQA.

Resolution #4 "Plastic ID Cards for Managed Care Patients" – St. Louis Metropolitan Medical Society
Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association develop with health care insurers a uniform electronic system of verifying patient eligibility with the costs being borne by insurers.

Resolution #5 "Missouri State Medical Association Sponsored Managed Care Organization" – St. Louis Metropolitan Medical Society
Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association, in cooperation with Missouri State Medical Services, Inc., Renaissance HealthCare Partners, Inc. and other sources, develop a report on the feasibility of organizing a physician owned and operated managed care organization and that this report be provided to the MSMA membership after being presented at the August 1996 MSMA Council meeting.

Resolution #7 "Proposed Constitution & Bylaws Changes"
Adopted Bylaw Changes

Change Bylaw sections that refer to "Hospital Medical Staff Section" to "Organized Medical Staff Section."

Add a section to the Bylaws on Affiliate Members.
Affiliate Members shall be those individuals who contribute to the health care of the public through employment service to MSMA members and component societies and who are not otherwise eligible for active membership. The criteria for affiliate membership and the policies governing the participation of affiliate members shall be established and maintained by the Council. Affiliate members shall have no voting rights nor will this class of membership apply toward House of Delegates or Council representation.

Proposed Constitution changes lay over until 1997 Annual Convention
Recommend change in "Article XII. Amendments" of Constitution to be voted on at 1996 Annual Convention.

Referred to MSMA Council the sections on "direct members."

Resolution #9 "Aid to the Republic of Georgia" – Boone County Medical Society
Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association express its support for the efforts of the Boone County Medical Society to provide help to the independent Georgian Medical Association and aid in the improvement of health care in the Republic of Georgia.

Continued on page 222

Steve Buie, MD, of Kansas City addresses the House of Delegates during the Second Session.

Continued from page 221

Resolution #11 "Inappropriate Antibiotic Use" – Lake of the Ozarks Medical Society

Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association join in the effort to educate physicians and the general public in the proper use of antibiotics by:

(a) sponsoring lectures throughout the state to component medical societies;
(b) public service announcements through television and radio;
(c) providing patient information material for distribution in physicians' offices.

Resolution #12 "Statewide Information Network" - St. Louis Metropolitan Medical Society

Substitute Resolution Adopted

RESOLVED, that MSMA complete its efforts in establishing a statewide information network.

Resolution #14 "Standardizing Claims Processing Methodology" - David R. Lange, MD

Referred to MSMA Council

RESOLVED, that the Missouri State Medical Association be opposed to arbitrary payment decision rules by organizations financing health care services in Missouri, and be it further

RESOLVED, that all physician claims for service be processed in accordance with the published CPT methodology, and be it further

RESOLVED, that retrospective review of claims submitted between January 1, 1992 and January 1, 1996 in which payment was inappropriately withheld due to the application on non-standard, arbitrary claims processing methodology and restitution be provided from such claims, and be it further

RESOLVED, that this resolution be considered by the AMA for national policy.

Resolution #18 "Conversion of Missouri's Blue Cross and Blue Shield Plans from Not-For-Profit to For-Profit-Status" - MSMA Council

Amended Resolution Adopted

RESOLVED, that the Missouri State Medical Association go on record in support of efforts to require Blue Cross and Blue Shield Plans in the state of Missouri which convert from not-for-profit to for-profit status to set aside a substantial amount of their net worth for appropriate charitable purposes, especially programs which help fund healthcare for Missourians who otherwise would not be able to afford it.

Resolution #20 "Immunizations" - Cape Girardeau County Area Medical Society

Not Adopted

Reference Committee B

Ted Groshong, MD of Columbia presented the report of Reference Committee B. The following items were placed on the Consent Calendar:

Report of the President
Report of MSMA Alliance
Report of Committee on Legislative Affairs
Report of the Secretary
Report of the Treasurer
Report of the Executive Vice President
Council Minutes
Report of the Missouri State Medical Foundation
Report of Physicians' Health Committee
Report of the Commission on Interspecialty Medicine
Report of the Commission on Medical-Legal Affairs
Report of the Committee on Publication
Report of the Public Affairs Commission
Report of the MSMA Television Project
Report of the Commission on Continuing Medical Education
Report of the Committee on Continuing Education and Health ManPower

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution #1 "Pharmacist's Patient Education" – Northeast Missouri County Medical Society

Resolution #2 "Drug Side Effects" – Northeast Missouri County Medical Society

Substitute Resolution Adopted in lieu of #1 & #2

RESOLVED, MSMA staff work with the Missouri Board of Pharmacy and the Missouri Pharmacy Association to develop guidelines to minimize duplicative and/or contradictory patient education, and to develop a mechanism to ensure that patients report drug side effects to the physician prior to drug cessation.

Resolution #6 "Health Care Bill for Managed Care Organizations" - St. Louis Metropolitan Medical Society.

Not Adopted

Guest speakers Stanley Pappelbaum, MD of Professional Health Consulting Group of Del Mar, California and Nancy Dickey, MD, Chair of the AMA Board of Trustees and Executive Committee held a well attended general session on managed care.

Resolution #8 "Highway Speed Limit" – Cape Girardeau County Area Medical Society *Not Adopted*

RESOLVED, that the Missouri State Medical Association support enforcement of current speed limits on Missouri's highways.

Resolution #10 "HIV Testing Without the Right of Refusal" – St. Louis Metropolitan Medical Society *Substitute Resolution Adopted*

RESOLVED, that the MSMA support the position that physicians should be allowed to perform HIV testing on patients, without mandatory prior consent, when such testing is medically indicated, and when possible, appropriate counseling is provided prior to reporting of test results, and be it further

RESOLVED, that physicians who are at risk of acquiring HIV infection, and who perform invasive procedures, should determine their HIV status.

Tim McIntire, MD, MBA, of Jefferson City Medical Group participated with Dr. Daniel O'Sullivan of MSMS, Inc., Dr. Douglas Westhoff of Mid-Missouri Medical Care, Inc., and Dr. Tom Allen of Renaissance Healthcare Partners, Inc., in a panel discussion about Physician Directed Networks in Missouri.

RESOLVED, that the MSMA be instructed to investigate and institute legislative and/or regulatory implementation of said testing, reporting back to Council at its June 1996 meeting, and be it further

RESOLVED, that this be carried forward as a resolution to the AMA at its June 1996 Annual Meeting.

Resolution #13 "Regulation of Tobacco" – Jim Blaine, MD, Greene County Medical Society

Adopted

RESOLVED, that the Missouri State Medical Association encourages the General Assembly of the State of Missouri to remove any and all language from SB 831 and HB 1247 having to do with preemption of any activity concerning tobacco on a local level.

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Resolution #15 "HIV Testing in Pregnant Women" – Greene County Medical Society
Substitute Resolution Adopted

RESOLVED, MSMA staff work with the Missouri Department of Health to develop guidelines relating to routine screening for HIV in pregnant women.

Resolution #16 "'Essential Community Provider' Legislation" - Metropolitan Medical Society of Greater Kansas City *Referred to MSMA Council*

RESOLVED, that physicians who maintain practices in medically underserved areas be designated "Essential Community Providers," and be it further

RESOLVED, that the Missouri State Medical Association support efforts to require managed care companies in the state of Missouri to take into account the special needs of patients in medically underserved areas and to include the services of Essential Community Providers in the care of those patients.

Oralee Puckett, (Beth, daughter of Dr. Darrel and Barbara Domann of Springfield) being assisted by Michael Zylka, MD, (spouse of MSMAA AMA-ERF VP Angela Zylka of St. Louis) in the auctioning of a painting by Jean Chapman, MD, of Cape Girardeau. The dinner and auction raised $7,400 for AMA-ERF.

Resolution #17 "Gag Clauses in Health Plans" – Metropolitan Medical Society of Greater Kansas City
Amended Resolution Adopted

RESOLVED, that the Missouri State Medical Association support legislation that forbids any restrictive rules which decrease the ability of physicians to communicate with patients and repeals any such rules currenlty in existence in our state, and be it further

RESOLVED, that the MSMA support legislation that will forbid any managed care company, hospital or medical service plan, health maintenance organization, an employer or employee organization, provider group, government entity, or a managed care contractor that operates a manged care plan, from preventing the physician from discussing medical treatment options with their patients, and be it further

RESOLVED, that the MSMA support legislation that protects the individual physician against dismissal or sanction for communicating a medical option relating to the patients care options by any healthcare plans or agencies discussed in the previous section, and be it further

RESOLVED, that the MSMA support legislation that will not allow any entity to refuse to contract with or compensate for covered services an otherwise eligible provider or nonparticipating provider solely because such provider has, in good faith, communicated with one or more current, former, or prospective patients, regarding the provisions, terms or requirements of the organization's products, as they relate to the needs of the providers' patients.

Resolution #19 "Screening for Hepatitis B Virus Infection in Pregnant Women" – William Taylor, MD
Not Adopted

Roy Holland, MD, of Greene County introduced himself as a Republican candidate running for the Missouri State House of Representatives, District 135.

Steve Buie, MD, of Metro Med of Greater Kansas City asked the House of Delegates to give attention to the Kennedy-Kassebaum bill, SB 1028. He encouraged members to start a grass roots letter writing campaign to Senators and Representatives in favor of the bill.

Vice Speaker John Rollo, MD, announced that Joni Scott, MD, was the winner for the weekend at Tan-Tar-A exhibitor drawing. Dr. Rollo then adjourned Second Session of the House of Delegates 1996 Annual Convention .

THIRD SESSION

Speaker DeFeo called the Third Session of the 138th Annual Convention to order at 7:30 a.m., April 14, 1996.

Gary Dyer, MD, gave the Supplemental Report of the Committee on Credentials. The following number of members have presented satisfactory credentials constituting the roll call of the 1996 Annual Convention of the House of Delegates of the Missouri State Medical Association: 9 Officers, 30 Councilors and 168 Delegates. The reported was adopted.

Speaker DeFeo recognized the attendance of past Executive Vice President Royal Cooper, to which the Delegates applauded. Dr. DeFeo then presented a special resolution and plaque to MSMA staff member Linda Bremer for 25 years of continuous service to the Association. She has been on staff since 1970 as secretary and now office manager.

Speaker DeFeo then announced the Election of Officers, AMA Delegates, and Alternate Delegates. Recommendations of the Nominating Committee are reported in the Second Session of the House of Delegates.

Hugh Stephenson Jr., MD, introduced and nominated A. J. Campbell, MD, as President-elect. Dr. Stephenson spoke of Dr. Campbell's father being a dedicated Pettis County physician and MSMA member, and of that A. J.was a top-notch student in the first class Dr. Stephenson taught at the University of Missouri-Columbia. Dr. Campbell is the first president from Sedalia in over 75 years. For 17 years he has represented the 6th District as Councilor and Vice Councilor. He has served his County Medical Society as president, and he has been a Delegate to the Hospital Medical Staff Section of the AMA almost since it was founded. After receiving his medical degree at the University of Pennsylvania in 1956, he spent several years in Family Practice training at the University of Michigan at Ann Arbor. He then returned to Sedalia where he has practiced for 39 years. He is a charter member of the American Academy of Family Practice.

Dr. Campbell married Janet Beaven. They have three children, two of whom are physicians. Janet is a past president of the MSMA Alliance and the Southern Medical Association Auxiliary. She instituted SMAA's Cancer Awareness Project. Dr. Campbell is also an Associate Councilor of the Southern Medical Association. Janet currently serves on the Ellis Fischel Hospital Cancer Advisory Board.

MSMA President-elect A. J. Campbell, MD and Janet Campbell of Sedalia.

The Campbells are devoted to community service and serve the Sedalia Symphony Board, the Sedalia Chamber of Commerce, Arrow Rock Lyceum Theater Board, United Way Co-chairman, and the First Presbyterian Church. Dr. Campbell has served as President of the MU Medical Alumni Board of Governors and is a member of the prestigious Steven McAlister and Jefferson Society.

Barbara Buchanan, MD, from the 7th Councilor District seconded the nomination for Dr. A. J. Campbell.

Dr. Campbell was then elected by acclamation by the House of Delegates, to which he thanked his colleagues for their confidence in him and expressed anticipation to working with President Dan O'Sullivan, MD, this year.

The rest of the Officers and AMA Delegates were then elected as presented by the Nominating Committee during the Second Session (*see page 220*).

Mark Kasten, MD, Vice Councilor, 10th District withdrew his nomination for Alternate Delegate, and the AMA Alternate Delegates nominated by the committee were elected.

Neal Sikka of Washington University, MSMA Medical Student Section nominated Josh Madden for the position of Alternate Delegate to the AMA, who was then elected.

The following members were elected Councilors and Vice Councilors:

District 1	
Councilor	Stephen Vilmer, MD
Vice Councilor	Robert O. Schaaf, MD
District 3	
Councilor	Newton White, MD
Vice Councilor	Randall Treadwell, MD
District 5	
Councilor	Jerry Kennett, MD
Vice Councilor	Robert Wankum, MD
District 7	
Councilors	Deborah Jantsch, MD William Dorzab, MD

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District 7 continued...
Vice Councilor .... Frederick DeFeo, MD
District 8
Councilor .... James Wolfe, MD
Vice Councilor .... Michael Hoeman, MD
District 9
Councilor .... David O. Barbe, MD
Vice Councilor .... Edward Jenkins, MD
Organized Medical Staff Section
Councilor .... Luis Anglo, MD
Vice Councilor .... Peggy Barjenbruch
Resident Physicians Section
Councilor .... Mary Vest-Mason, MD
Vice Councilor .... Howard Pomerantz, MD
Medical Student Section
Councilor .... St. Louis delgation elects at a later date
Vice Councilor .... Vasu Kakarlapudi

SSOURI STATE
CAL ASSO
Dr. Rollo
Dr. DeFeo

MSMA Staff member Linda Bremer received a plaque presented by Vice Speaker Rollo and Speaker DeFeo, in recognition of 25 years of service to MSMA.

Vice Speaker John Rollo, MD, directed unfinished business from the previous meeting of the House of Delegates. The Delegates approved Recommendation No. 2 of Resolution No. 7.

Norman P. Knowlton, III, MD, MSMA Secretary, then installed the Officers, Councilors, Vice Councilors, AMA Delegates and Alternate Delegates.

Vice Speaker Rollo then called President Daniel O'Sullivan to give the President's Appointment of Committee and Commission Chairs. Dr. O'Sullivan announced the following chair appointments:

Committee on Constitution & Bylaws
Donald Potts, MD, *Kansas City*
Physicians' Health Committee
Thomas Anderson, MD, *Columbia*
Committee on Planning
Herluf Lund, MD, *St. Louis*
Committee on Publication
J. Regan Thomas, MD, *St. Louis*
Committee on Legislative Affairs
Robert Miller, MD, *St. Louis*
Commission on Continuing Education & Health Manpower
Michael Vannier, MD, *St. Louis*
Commission on Medical Economics, Third Party Medicine & Governmental Relations
Randall Treadwell, MD, *St. Charles*
Commission on Medical-Legal Affairs
Marc Taormina, MD, *Columbia*
Commission on Public Affairs
Ann L. Peick, MD, *Poplar Bluff*
Council on Ethical and Judicial Affairs
Hugh Stephenson Jr.,MD, *Columbia*

Dr. O'Sullivan announced that he will be available throughout the year for visits to local and county societies to help stimulate membership.

Dr. Rollo then invited the announcements of the next two Annual Convention sites. The 139th Annual Convention will be April 10-13, 1997, at the Westin Crown Center in Kansas City. The 140th Annual Convention will be April 16-19, 1998, at the Marriott Pavilion Hotel in St. Louis. The 141st Annual Convention April 8-11, 1999, here at Tan-Tan-A. The 142nd Annual Convention will be in Kansas City, place yet to be determined. An invitation for the 143rd Annual Convention was made to be held in St. Louis in the year 2001.

Octavio Chirino, MD, then added a point of personal privilege, to recognize Jack Kayes, MD, who will be finishing his term as AMA Delegate in December. Delegates stood and applauded Dr. Kayes dedication to MSMA.

Vice Speaker Rollo then conducted the motion of St. Louis being the site for the convention in the year 2001.

Following the passing of this motion, Dr. Rollo declard the 138th Annual Convention of the House of Delegates adjourned.

A complete copy of the transcripts for the 138th House of Delegates is available at MSMA Headquarters. Call Linda Bremer at (573) 636-5151, to obtain a copy.

Excerpts of Dr. Dickey's Address to the House of Delegates

You have already heard two speakers this morning, your President and President-elect, tell you that times are changing. In fact, things are changing so rapidly that we describe the environment as fluid or revolutionary.

The goal of the American Medical Association, working with the Missouri State Medical Association and each of your local societies, is to help chart a path for our profession and for our patients, to protect each of you, to protect the profession, and to continue to make patients central to that which we do every day.

You will recall the Old Testament story of the two individuals who built houses, one upon the sand and one upon the rock. When the storm came, the house upon the sand did not have a strong enough foundation to stand. Organized medicine helps us find that solid rock foundation. A foundation of ethics that put our patients first and tell us on what we build. A foundation of standard setting that helped us create one of the finest medical education and research systems in the world. A foundation that says quality of care is what's most important even as we are being buffeted by socioeconomic changes.

Let me share with you two or three key issues that are important and will help us to continue to build on those foundations.

You will recall from reading the newspapers just a few days ago, we had another merger of major health providers. United Healthcare and Aetna came together and combined to form an entity that now covers one in twelve Americans. The government said, "Okay that is probably good for health care." Hospital mergers occurred with the purchase of over 350 hospitals making one of the largest for profit hospital chains ever seen in the United States. And the government said repeatedly, "Okay. You can do that."

But when physicians came together and attempted to form a network that would help them provide better care and set standards of quality as they did in Montana and in St. Joseph, Missouri, the government said no. You can't do that. It's not good for providing care. It's not good for patients. And in fact not only said, no, you can't do it, but had penalties to be paid.

We have been talking to the FTC for over ten years to say to them, the rules don't make sense. They aren't applied fairly. In fact, we finally talked some legislators into writing a bill that would tell the FTC what kinds of enforcement guidelines ought to be used to level the playing field – not to give new regulations, not to change anything for physicians, just to enforce for doctors the same way they enforce for plans and for hospitals. Just to give the same rules, rather than tougher interpretations for doctors. I had the opportunity to give the AMA testimony at the House Judiciary Committee where the FTC had just preceded us and said "You don't need legislation. We will ease up on the doctors a little bit. Trust us. Trust us."

Featured speaker Nancy Dickey, MD, Chair of the AMA Board of Trustees and member of the AMA's Executive Committee.

We don't think you can trust them. We have been visiting them almost weekly for many, many years. We have lined entire walls of filing cabinets with our papers. In fact, it was suggested that we erect a statue in the square for the persistence of the American Medical Association's General Counsel in his attempt to change the FTC's perspective.

We believe we need the Hyde Antitrust Bill. In order to get that, we need you. We need Congress to understand why trusting the FTC for over a decade is not the solution and why Congress needs to act.

We think two of your senators are supporting the FTC movement, but they have yet to get a vehicle in order to express that sentiment. There is a great deal of work for each of you to do, to talk to and encourage a changed perspective for those many Congressmen and women who have not yet seen why we need legislation – not "trust me from the FTC.

Secondly, this is an election year. We have an opportunity to solidify our friendships with those that we already have relationships with and to form new relationships, new friendships. If you don't contribute to your PAC, think about it. That's a very powerful message and they know it comes from the House of Medicine.

If you haven't yet looked to see who is running in your district, then you ought to choose a candidate. We need supporters on both sides of the aisle because whoever wins, we want to know there are people who can knock on the door, ring the phone and get an answer.

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Checks are fast and easy and a good way to offer support. Volunteer time is cheap. Either way the winner will remember who was on his or her side when they go to Washington after the election this November. Please be active in this election year, so we can call upon you in the next two to four years when issues that are important to your patients come about.

Finally, probably the key to that rock foundation, but one that is threatening to be very shaky, is our ethical code. One of the reasons AMA was founded 150 years ago was the need to establish a firm commitment to an ethical guideline because medicine was being assaulted on all kinds of fronts by quackery and by people who were not adequately trained. That ethical code has stood us in good stead for 150 years, yet today we find everything from managed care and the effort to put money before patients, to our relationship with terminally ill patient is fodder for newspapers, for senate committees and for doctors to discuss.

Sometimes we win, as we have with the gag clause, where we said firmly, we will discuss what is good for our patients and what alternatives are there, whether or not the insurance companies will pay for that. That has been a strong and powerful message for medicine.

Some of them, we're still questioning where we want to be. Physician-assisted suicide, for example, and our care of the terminally ill. We have found ourselves resolutely saying that organized medicine is opposed to physician-assisted suicide. That it is not the physician's role to take a patient's life, and at the same time to recognize that we may need to improve and change the way we relate to terminally ill patients.

Yet in the last few months we have found assault after assault from society about whether that is the right position. Kevorkian has been let off yet again in spite of the fact that he is freely using at the bedside carbon monoxide for pain relief. Two federal appeals courts—perhaps are far more bothersome than Kevorkian—have strongly encouraged states to begin looking at whether they should establish guidelines for how physicians and how health care should participate in assisting suicide because of the rights of patients to choose when they will die.

What is the right position for medicine? How should we relate to our patients when they're terminally ill? Then once strongly decided, how do we make sure we communicate that appropriately?

Our code continues to say that it is not appropriate for physicians to participate in assisted suicide, and at the same time we must know when it is time to stop, turn off the technology, and to become compassionate, supporting caregivers who assist patients in a dignified dying. But we will have to deal with a society who is questioning that particular standard.

Each of these and many other issues demand a unified voice. They demand that we have the courage to come together, to question long and healthily to decide whether they are the right ones or the wrong ones. If they are the right ones, how to move forward. If they are the wrong ones, how to change and begin to create the right policy for ourselves.

We need a voice with a solid, ethical foundation and a voice committed to what is good for our patients, even as we're attempting to survive economically in these times. We need each of our voices at a time when membership numbers are frankly faltering at county, at state, and certainly at the AMA level.

It is time to decide how we can get an organization that is stronger and bigger, that represents far more of us than the current 40-41%, and that will continue to put our patients at the center of each and everything that we decide as the measuring stick for whether it is the right thing or the wrong thing to do.

Together we can continue to make a difference and we can continue to look at our new young colleagues joining the profession and say to them that this profession continues to have good times, different times perhaps than doctors of 40 years or 50 years ago, but good times because they are exciting times to help our patients. That's what we are all about.

So help us find ways to find that unified voice. If the solutions to the federation study aren't the right ones or the best ones, then give us your suggestions, your alternatives. Don't just say no.

If the ethical foundation isn't the right one today, help us find what the right message for our patients and our communities is, and then a way to carry it forward. Continue to help us to be a strong voice as the legislators continue to be a huge part of the definition of what medicine will look like and how you and I will practice.

Together, I know we can continue to have pride in this profession well into the 21st Century and continue to let the organization help the foundation to be solid as a rock and to continue to cope with change. MoMed

A complete version of her address is included with the transcripts of the 138th MSMA Annual Meeting.

Reports Referred to Reference Committees

President's Report - see page 200
MSMA Alliance Report - see page 239
Report of Treasurer - Financial Statements, March *Missouri Medicine.*

Report of Secretary

The Missouri State Medical Association had 5,660 members of the December 1995 audit. This was a net loss of 9 members from our membership of 5,669 on December, 1994 audit. Following is a breakdown according to classification:

Year	Students	Residents	Active	Honor	Total
1994	369	207	4,086	1,007	5,669
1995	370	206	4,065	1,019	5,660
	+1	-1	-21	+12	-9

Number of member deaths reported during 1995 totaled 70.

Report of the Executive Vice President

Uncertainty! That best describes the mood of many Missouri State Medical Association members as the mode of medical practice continues to change.

At the direction of this House of Delegates, the MSMA is continuing its efforts to establish some reason in the process of change. In the Missouri General Assembly, Association members and staff are pressing forward with the Patient Fairness Act (SB 641/HB 1206) and several other bills that will protect the rights of both patients and physicians. It has been a difficult chore to date due to the opposition of the business community, labor groups, the insurance and managed care industry, individual major Missouri employers and even some physicians. This same coalition is also opposing our efforts to reform the state's insurance laws by providing employees with insurance portability and eliminating pre-existing illness clauses from policies. A report of the Committee on Legislative Affairs available at this meeting will provide Delegates with in-depth information on the important activities in the Missouri Capitol.

Equally important as legislation are regulations proposed by state agencies that affect the medical profession or patients. In the past year, the Association was primarily responsible for having four proposed regulations withdrawn and offered language changes that deleted or altered detrimental sections in six other proposed regulations.

The Association continues it involvement in attempting to secure physicians' right to control their destiny through the efforts of the Missouri State Medical Services, Inc., a subsidiary established last year. We are also providing input and representation to the Department of Health's CHART Program and the Robert Wood Johnson project to study possible changes in the state's health care system.

Finances: Although the MSMA has the second lowest dues of the 50 state medical societies, the Budget Committee felt the Association's financial condition was sound enough to avoid a dues increase at this time. The last dues increase was in 1986.

Membership: As the Association and member physicians face more and more challenges, it is a great disappointment that membership continued a slight decline in 1995. If all non-member physicians in Missouri would join, the dues could be even lower than they are now. Association leadership and staff will be concentrating more on increasing membership in the coming year but we need the assistance of each current member to recruit their non-member colleagues.

Overview of the Association: All nonmembers of MSMA owe dues-paying members a debt of gratitude! Your efforts and participation have made the MSMA the pre-eminent medical organization in our state. Our efforts in the Legislature and with the bureaucracy are highly respected by friends and foes alike. The services and assistance we offer our members and the public are many. This is an organization that members can look to with pride. However, many of our members are unaware of the many benefits the Association does offer. Please review the Association brochure that was included in the packet you received when registering to see if you are taking advantage of all that is available through your Association.

Officers and Others: I would like to thank all of the MSMA Officers and Councilors for giving freely of their time and efforts during many weekend meetings year after year. I especially appreciate the dedication of Drs. Frederick Hahn, Daniel O'Sullivan and A. J. Campbell in dealing with the many problems that all leaders must tackle. I also want to thank those many members that serve on Association committees and commissions and those who willingly travel to Jefferson City to make important contacts with their Legislators.

Staff: The entire staff and membership was deeply saddened by the sudden, unexpected death of Mrs. Rose Mahon, who had served as our Officer Manager for 27 years. She will always be missed.

Carrying out the directives of this House of Delegates and the Council is the charge for your staff of 12. Those of you who have worked with or sought assistance from staff realize the dedication and expertise they provide to the medical community and to the public. We all owe each of them our sincere appreciation. Along with discharging the directives of the Association, we provide staffing for nine specialty societies, MMPAC, the Physicians Health

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Program, the Missouri State Medical Foundation and the Missouri State Medical Services. As you enjoy this Annual Convention, take a moment and visit with staff. It will be of benefit to both. Thank you for the privilege of serving!

C. C. Swarens

Summary of 1995-96 Council Minutes

Meeting of March 26, 1995, St. Louis

Election of the following officers:

President-elect	Daniel O'Sullivan, MD, *St. Louis*
Secretary	Norman P. Knowlton, III, MD, *Springfield*
Treasurer	David Wilkinson, MD, *St. Louis*
Council Chair	A. J. Campbell, MD, *Sedalia*
Vice Chair	Stephen Vilmer, MD, *Parkville*

Council approved redemption of outstanding debentures that were used to help establish MOMEDICO.

Meeting of June 11, 1995, Lake of the Ozarks

A membership recruitment drive was announced to increase membership on all levels of the Federation. President-elect Daniel O'Sullivan, MD and a Vice Councilor from each district will attempt to identify nonmembers and encourage them to become involved by one-on-one contact with members.

Council approved expending $2,500 for the Study of the Federation, a joint effort of local, state and AMA representatives to redefine the roles of medical societies. Staff was instructed to determine the cost of providing services to specialty societies to establish a fair rate of reimbursement for the specialties and MSMA.

MSMA's Physicians' Health Program reported assisting 81 impaired physicians.

MSMA's Health Education Foundation indicated that the Association's health news television spots were being shown three times a week in St. Louis and would be shown in Columbia/Jefferson City and Springfield markets.

Council approved the St. Louis Marriott's Pavilion as the site of the 1998 MSMA Annual Convention. Staff was asked to investigates ways to improve student involvement and attendance at MSMA Annual Convention.

Council endorsed the nomination of Carl Myers, MD, of Platte City, as a member of the Board of the Healing Arts.

The following Councilors were appointed liaisons to MSMA's committees and commissions: Gordon Goldman, MD - Continuing Education and Health Manpower; Carl Kruse, MD - Interspecialty Medicine; Jerry Kennett, MD - Medical Economics, Third Party Medicine and Governmental Relations; Meredith Payne, MD - Medical-Legal Affairs; Linda Dorzab, MD - Public Affairs; David Wilkinson - Physicians' Health.

Meeting of August 12, 1995, Columbia

MSMA President Fred Hahn, MD, proposed and alliance between component medical societies and Rotary International to create programs to increase the level of infant and toddler immunizations. He encouraged the two groups to work with local physicians, public health officials, and the private sector. Goals include assisting family physicians and pediatricians in implementing current immunization practices, assessing immunization levels and ensuring continuity of this statewide project.

Following a report by Kathryn Kiefer of KLK Communications, field producer for MSMA video project, the Council voted to extend the project through 1996. Expansion of the project was referred for study to the Commission on Public Affairs to report at the November meeting.

Council nominated Arturo Montes, MD and James Rogers, MD, for reappointment to the MPCRF Board. Jerry Kennett, MD, was nominated to serve a committee established under the Missouri Health Systems Partnership.

Council Chair A. J. Campbell named the Committee on Arrangements for the 1996 Annual Meeting: Drs. Robert Wankum-chair, David Barbe, and William Shell.

Council voted to reinstate joint meetings of MSMA, MAOPS, and MHA executive committees.

Council voted to expend approximately $6,000 to the AMA Litigation Center. The Center is will provide expertise of the AMA Legal Department when requested by state societies.

Council authorized staff to pursue the offering of an "affinity" Master Card by MSMA to its members.

Council voted to support a preceptorship program for Missouri medical schools as recommended by the MSMA Medical Student Section.

Council recommended that the Missouri State High School Athletic Association (MSHSAA) use the standard physical examination form recommended by several medical organizations. A letter of recommendation was forwarded to the MSHSAA.

Council voted to establish a consent calendar for noncontroversial items on the Council agenda.

Meeting of November 12, 1995, Jefferson City

Council approved the 1996 operating budget of $1.7 million, which represented a 9% reduction from 1995, and recommended no dues increase for 1996.

Council approved recommendations by the Committee on Constitution and Bylaws as follows:

a. Dues for military physicians be the same as nonmilitary.
b. Executive Committee develop "Rules and Procedures for Governing the Council."
c. Prepare Bylaws change for the House of Delegates that

would recognize that MSMA can accept "direct" members from component societies that accept "local only" members.

d. Develop Bylaw language to recognize affiliate members, to make local society staff and employees of private physicians' offices eligible for Association insurance programs and other benefits.

Council authorized the following for MSMA shareholder voting rights in MSMS, Inc.: Drs. Daniel O'Sullivan, Frederick Hahn, A. J. Campbell, H. Jerry Murrell, Norman P. Knowlton, III, David Wilkinson, William Dorzab, and Mr. C. C. Swarens with one or all being able to vote a the MSMS Annual Meeting.

Mark Aeder, MD, of Kansas City, was nominated for a vacancy on the MPCRF Board. Council also voted to encourage the MPCRF to have at least 75% of its physician board members be involved in active practice at least 50% of the time. It was also suggested that board votes on peer review matters be limited to practicing physician board members.

Norman P. Knowlton, III, MD, was reappointed to the MOMEDICO Board. Council approved switching the Association's endorsed major medical plan for members from CNA to New York Life.

Council recommended that the Publications Committee review the effectiveness of *Missouri Medicine* and *Progress Notes* and make recommendations in light of rising costs of publications.

Council approved action taken by the Executive Committee at the request of the Department of Health for assistance in resolving problems with their HIV/AIDS program.

MPHP reported an 11% increase in participation from 1993 to 1994. To date, 89 physicians have taken advantage of MSMA's impaired physicians' service.

Council approved scheduling a seminar during the Annual meeting to train physicians to participate in local medical programs on local access and small station outlets and to develop an MSMA Internet Home Page.

Missouri AMA Delegates were instructed to attempt to have the recently released report on the Study of the Federation referred for further study by all state medical associations and postpone a final vote until the 1996 AMA Annual Meeting.

Council approved a consent calendar containing the reports on the following: Physician's Health Committee; Committee on Continuing Medical Education; Medicaid/CHART/Robert Wood Johnson; Peer Review Consultant System; and MSMA Video Project.

Meeting of January 28, 1996, Jefferson City

The Executive Committee nominated Ronnie Brownsworth, MD, Springfield, and Tim McIntire, MD, Jefferson City, to serve on a task force to create a standard credentialing form.

The MMPAC Board approved contributions for various candidates and asked that MSMA sponsor a program at the Annual Convention to enlighten physician on how to become involved with individual candidates.

Council instructed staff to study other locations in Missouri as sites for the Annual Meeting. A discussion session on the AMA Study of the Federation was approved for the Annual Meeting and regional meetings thereafter to bring the issue to members' attention.

Council nominated Norman P. Knowlton, III, MD, to serve as the MSMA liaison to MOMEDICO and at his direction, approved appropriate royalty payments to MSMA for endorsement.

Frederick Peterson, MD, St. Louis, was recommended to serve the Quality Assessment and Improvement Group and Ted Groshong, MD, Columbia, would serve as an alternate.

William Huffaker, MD, was reappointed to served on the Medicare Practicing Physicians Advisory Council.

Council accepted the consent calendar containing reports on the following: Physicians Health Committee, Committee on Continuing Medical Education, Commission on Public Affairs, and Medicaid.

At the request of District 3 and after consultation with MSMA legal counsel, Council voted to adapt information on informed HIV consent forms/patient testing for use in Missouri.

At the request of Newton County, Council approved its merge with Jasper County, to be called: Jasper-Newton Metropolitan Medical Society.

Carl Myers, MD, Platte City; Richard Gulick, MD, St. Louis; and Barry Spoon, DO, Springfield, were nominated to fill three expired terms on the State Board of Registration for the Healing Arts.

Meeting of April 10, 1996, Tan-Tar-A Resort

Council approved a waiver of dues for members serving in Bosnia, in response to a request by the AMA.

Council approved a cosponsorship between MSMA and AMA of a Regional Family Violence Conference.

Mr. Swarens, EVP, reported that the credit card program for MSMA is being implemented and information will be available to members at the Annual Meeting. Also, that a readership survey for *Missouri Medicine* was mailed

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to 1,400 members with a response rate to date of 15%.

MSMA's conjoint project with Sprint to provide Internet service to MSMA members will be available soon. This network will be prototype for other state medical associations.

Mr. Swarens also reported that MSMA will begin a vigorous membership campaign this summer, and that the HIV brochure and consent to testing form will be available in a few weeks.

MSMA President Frederick Hahn, MD, reported the following actions taken by the Executive Committee since the January Council meeting:

1. The Executive Committee will hold a conjoint meeting with the executive committees of MHA and MAOPS in August.
2. MSMA will support the candidacy of Dr. Robert L. Phillips for the resident position on the AMA Council on Medical Education.
3. MSMA ceased operation of the TV project on Feb. 29.
4. MSMA will continue to pursue mutually agreed upon benefits without amending the jointly agreed "License Agreement" with MOMEDICO.
5. MSMA filed an amicus brief in the Missouri Supreme Court case, *Gildewell v. S. C. Management*. The case would negate a section on joint and several liability of the medical malpractice bill passed in 1986.
6. MSMA will include prepaid income tax audit defense service provided by Tax Resource as a membership benefit.

Council approved the following to vote MSMA proxies with MOMEDICO: Drs. Norman P. Knowlton, III, Meredith Payne and/or Mr. C. C. Swarens.

Council approved the consent calendar containing the Report of the TV Project and the Report on the Internet Project.

Council approved the submission of a late resolution.

Mr. Tom Bennett, EVP of MSMS, Inc., reported that the MSMS Board would consider a proposal by the Saint Louis Management Group, Inc. for "Developing and Operation of a Statewide Management Services Organization" at the board meeting held during the Annual Meeting. Upon approval, the proposal would be presented to the Council at a future meeting.

Commission on Medical Economics, Third Party Medicine, and Governmental Relations

The numbered resolutions were referred by MSMA 1995 House of Delegates to MSMA Council which assigned them to this Commission for study and recommendation:

Resolution #1 - Any Willing Provider Legislation Limited to Rural Areas The Commission recommended this resolution **not be adopted** because MSMA has the Patient Fairness Act as part of its legislative agenda which does not allow any willing provider.

Resolution #4 - AMA Survey on the Quality of Care in For Profit Managed Care Plans The Commission recommended this resolution **not be adopted** because the AMA has already begun their Private Sector Advocacy Team which is doing what this resolution requests.

Resolution #6 - Shifting Choice of Health Care Benefits Away from the Employers to Employees The Commission recommended this resolution **be adopted** and forwarded to the AMA 1995 Interim Meeting.

The Commission also drafted the following resolution recommending it to the MSMA Council:

RESOLVED, that the AMA create an **action plan** for developing a sense of Value and Worth in patients for the services received from their personal physicians and from the medical community at large. This program will serve as a **marketing plan** to physicians' patients to appreciate the physician-patient relationship.

Carl F. Strauss, MD, Chair; Luis B. Anglo, MD; Kenneth J. Dempsey, MD; Albert W. Marchiando, MD; Milamari A. Cunningham, MD; Ronald N. Riner, MD; George P. Hubbell, MD; James T. Rogers, MD.

Committee on Continuing Medical Education

The Committee on Continuing Medical Education met on May 30, August 8, Oct. 10, 1995 and Jan. 18, 1996.

The Committee members discussed the Fourth Annual Conference on Continuing Medical Education that was held September 29-30, 1995 in St. Louis, Missouri. There were 45 participants including CME coordinators, hospital administrative staff, physicians serving on CME committees, component medical society staff, and specialty program chairs. The featured speaker for this Conference was Joseph Green, Ph.D., Vice President, Educational Affairs, Sharp HealthCare, San Diego, Calif.

It was also suggested that the MSMA Annual Convention would be an excellent opportunity to inform members about the Essentials that an institution/organization must meet to become accredited as a sponsor for Category 1 continuing medical education (CME) activities.

As an accredited organization, MSMA has received several requests from non-accredited organizations to jointly sponsor Category 1 activities. In order to be more responsive to MSMA members, the Committee discussed the feasibility of jointly sponsoring CME activities with medical organizations affiliated with MSMA. Such jointly sponsored activities must be consistent with the MSMA Mission Statement. To jointly sponsor CME activities, MSMA would be able to provide more accredited CME offerings to the membership and generate additional income for the Association.

Recommendation: MSMA develop appropriate policies and procedures to support Joint Sponsorship of CME activities.

The Committee reviewed two programs for Joint Sponsorship:

1. Medical Legal Symposium, September 16, 1995
2. Missouri State Orthopaedic Association Annual Convention, September 7-10, 1995.

Committee members reviewed summaries of the participant evaluations from these educational offerings.

MSMA has been requested to jointly sponsor educational offerings with the St. Louis STD/HIV Prevention Training (PT) Center. The St. Louis PT Center has been funded by the Federal Center for Disease Control (CDC) for five years to produce training programs regarding the care of STD patients and make them available to the clinicians of the Public Health Service Region VII (Missouri, Iowa, Nebraska, and Kansas).

A motion was made, seconded, and approved to jointly sponsor the educational offerings with St. Louis STD/HIV Prevention Training (PT) Center.

The MSMA Mission Statement for Continuing Medical Education was reviewed and approved deleting the following paragraph:

The Missouri State Medical Association regularly publicizes ongoing Category 1 programs in its monthly publication, *Missouri Medicine*. Accredited sponsors are encouraged to use this publication as a means of publicizing their programs.

This statement will be incorporated into the MSMA CME Policies and Procedures Manual. MSMA will continue to publish Category 1 offerings in *Missouri Medicine*.

The Committee members reviewed a draft of a Policy on Mergers of Accreditation Sponsors. It was recommended that this draft be revised to conform to the CME Policies and Procedures.

Committee members recommended that the following organizations be recognized as sponsors for CME activities based upon their compliance with the Essentials and Guidelines for Continuing Medical Education:

Barnes St. Peters Hospital, *St. Peters*
Baptist Medical Center, *Kansas City*
Boone County Medical Society, *Columbia*
Buchanan County Medical Society, *St. Joseph*
Cape Girardeau County Area Medical Society, *Cape Girardeau*
Children s Mercy Hospital, *Kansas City*
Cox Health Systems, *Springfield*
Deaconess Medical Center, *St. Louis*
Doctors Regional Medical Center, *Poplar Bluff*
Fairfax Community Hospital, *Fairfax*
John Fitzgibbon Memorial Hospital, *Marshall*
Golden Valley Memorial Hospital, *Clinton*
Greene County Medical Society, *Springfield*
Incarnate Word Hospital, *St. Louis*
Independence Regional Health Center, *Independence*
Kansas City Society of Ophthalmology and Otolaryngology, *Kansas City*
Kansas City Southwest Clinical Society, *Kansas City*
Kansas City Veterans Administration, *Kansas City*
Lee s Summit Community Hospital, *Lee s Summit*
Lutheran Medical Center, *St. Louis*
Menorah Medical Center, *Kansas City*
Missouri Baptist Medical Center, *St. Louis*
Phelps County Regional Medical Center, *Rolla*
St. Louis Society for Medical and Scientific Education, *St. Louis*
St. Mary s Health Center, *St. Louis*
Trinity Lutheran Hospital, *Kansas City*

We appreciate the participation of the following Committee members:

Michael Vannier, MD, Chair, *St. Louis*; Gerald Duling, MD, *St. Charles*; John Kelly, MD, *Joplin*; Richard Heimburger, MD, *Osage Beach*; George Trimble, MD, *Kansas City*; David Martin, MD, *Chesterfield*; York Silliman, MD, *St. Joseph*; Gregory Tobin, MD, *Cape Girardeau*; Aly Mohsen, MD, *Springfield*; William Larsen, MD, *Shawnee Mission, Ks*; Mark McClung, MD, *Kansas City*

Commission on Continuing Education and Health Manpower

In accordance with the MSMA Bylaws, the Commission on Continuing Education and Health Manpower shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as make all arrangements for each Annual Convention, subject to the instructions of the House of Delegates.

Members of the Commission on Continuing Education and Health Manpower have been instrumental in formulating a planning calendar to assist specialty program chairs in developing their respective scientific sessions. This document requested such information as needs assessment, program objectives, Faculty Disclosure Forms, and the appropriate Letters of Agreement between the specialty organization and commercial entities. Participant evalua-

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tion forms will be obtained immediately following each scientific session held in conjunction with the MSMA 138th Annual convention.

Members of the Commission reviewed a draft of the Official Program to ensure that the content is in compliance with the Essentials, Guidelines, and Standards.

We appreciate the participation of the following Commission members:

Michael Vannier, MD, Chair, *St. Louis*; Gerald Duling, MD, *St. Charles*; William Gondring, MD, *St. Joseph*; John Kelly, MD, *Joplin*; Richard Heimburger, MD, *Osage Beach*; David Glover, MD, *Warrensburg*; George Trimble, MD, *Kansas City*; David Martin, MD, *St. Louis*; York Silliman, MD, *St. Joseph*; Gregory Tobin, MD, *Cape Girardeau*; J. Thomas Critchlow, MD, *Cape Girardeau*; Aly Mohsen, MD, *Springfield*; William Larsen, MD, *Shawnee Mission, KS*; Mark McClung, MD, *Kansas City*.

Missouri State Medical Foundation

Since its inception in 1961, the Missouri State Medical Foundation has loaned more than $4.7 million to Missouri medical students. For the 1995-96 school year over $280,000 has been loaned to students. The Foundation enjoys a very strong financial standing and has again received an unqualified opinion from the auditor. For 1995, there was a net income of more than $160,000.

The current financial strength of the Foundation is due to the strong support received from the MSMA and the MSMA Alliance. MSMA members were assessed $10 a year until 1987 and the Alliance has targeted the Foundation for contributions through Christmas fund raising efforts.

Currently, more than fifty borrowers make monthly loan payments through electronic funds transfer from their bank account to the Foundation bank account - truly paperless. This year communication through electronic mail will be possible, further reducing administrative costs to the Foundation.

MSMF Board of Trustees: Miles C. Whitener, MD, President; Frederick W. Hahn, MD, Vice President; Robert H. Tanner, MD, Secretary-Treasurer; Patrick B. Harr, MD; Harold H. Lurie, MD; Robert O. Schaaf, MD; James E. Allan, MD; Christopher H. Jung, MD; Donald Fakhoury, MD

Report of the Physicians Health Committee

The Missouri Physicians Health Committee met on March 24, September 23 and January 27, 1995.

The Committee members approved the addition of two additional components to the structure of the Missouri Physicians' Health Program-Psychotherapy Group and Significant Other Group.

Group psychotherapy has been recognized as a valuable and useful adjunct to monitoring and advocacy agreements. The Psychotherapy Group provides an excellent opportunity to address interpersonal and intrapersonal issues uncovered by the abstinent state. This group provides a peer support system and professional guidance for developing a more effective recovery coping system. The Missouri Physicians' Health Program (MPHP) participants will be required to attend weekly group psychotherapy sessions for one year. It is hoped that group participants will develop a network within the group to act as support to each other during the lifetime of the group.

The Significant Other Group (DeNovo Program) would provide support through a monthly meeting open to physician's spouses, family members and significant others. Topics discussed during these monthly meetings may include substance abuse, mental health, violence and marital difficulties. It is the MPHP's goal to develop this program in communities that now have regional coordinators.

The psychotherapy and significant other groups will greatly enhance the quality of the Missouri Physicians' Health Program and its ability to continue to provide a highly effective monitoring program.

The Board of Healing Arts has implemented a Memorandum of Understanding between the Board, MSMA and the Missouri Association of Osteopathic Physicians and Surgeons Physicians Health Program. The purpose of this agreement is to establish a cooperative relationship between the three organizations that will safeguard the public and provide physicians the opportunity to return to practice through a system of detection, early intervention, effective treatment and monitoring.

The Board of Healing Arts, through the Memorandum of Understanding, has continued to demonstrate a strong spirit of understanding. The MPHP is pleased to acknowledge the improved communications and support of the advocacy for participants who have business before the Board.

The MPHP staff have mailed contribution letters to 147 hospitals in Missouri asking them to become "Key Supporters." These hospitals received three letters: one each to the administrator, president of the medical staff and the medical staff coordinator. It is anticipated that the hospital contributions will exceed the 1995 projections. "Key Supporters" of the MPHP have been published in the January issue of Missouri Medicine. The Missouri Physicians' Health Program would like to thank the "Key Supporters" for their generous contributions. It is because of this support that the MPHP can continue to assist physicians who are having problems which prevent them from functioning at their best.

As the Committee members reviewed the 1996 proposed expenditures, it was noted the increase in travel and consultant fees were based upon the expanding referrals and the need for staff to respond promptly. The improved financial condition of the MPHP is largely due to the enhanced contributions from hospitals and medical staffs as well as increased financial support from program participants' fees.

A motion was made and seconded to approve the 1996 Proposed MPHP budget.

We appreciate the participation of the following Committee members:

Tom Anderson, MD, *Chair*; Charlotte Balcer, MD, *Jefferson City*; Hugh Barlett, MD, *Rolla*; Donald McIntosh, MD, *Lee's Summit*; Jo-Ellyn Ryall, MD, *St. Louis*; K. Lynn Moritz, MD, *St. Louis*; Charles Sincox, MD, *Washington*; William Soper, MD, *Liberty*; Thomas Cochran, MD, *Springfield*; C. John Ritter, MD, *Cape Girardeau*.

Commission on Interspecialty Medicine

The Commission on Interspecialty Medicine met on June 26, 1995.

The Commission members reviewed the Report of the Ad Hoc Committee on the Annual Convention that was referred by the MSMA Council and endorsed the recommended changes. The members were encouraged to convey the proposed revisions to their respective specialty organizations for comments.

The Commission members discussed patient access to specialists. The members also reviewed the Patient Fairness Act that was introduced in the 1995 General Assembly.

The Commission members reviewed articles regarding the efforts of state medical societies in forming a managed care plan owned and operated by physicians.

The Commission members were invited to participate in the August Legislative Meeting that was sponsored by MSMA. This meeting involved major health care provider groups, medical specialty societies and patient groups to develop a coordinated strategy for the 1996 Legislative Session.

The Commission members discussed plans for their respective specialty functions that will be held in conjunction with the 138th MSMA Annual Convention on April 11-14, 1996 at Marriott's Tan-Tar-A Resort in Osage Beach, Missouri. The members also reviewed the requirements set forth on the 138th Annual Convention Planning Calendar.

We appreciate the participation of the following Commission members:

William Crowley, MD, Chair, Neurology; Greg Renner, MD, Otolaryngology; Jay Portnoy, MD, Allergy; Ruth Millett, MD, Pathology; Richard Nelson, MD, Anesthesiology; Bernard Griesemer, MD, Pediatrics; George Hruza, MD, Dermatology; Thomas Lieb, MD, Physical Medicine; Michael Szewczyk, MD, Emergency Medicine; Fred Thompson, MD, Plastic Surgery; Mark Martin, MD, Family Practice; Tom Anderson, MD, Psychiatry; Carl Strauss, MD, Internal Medicine; Roger Francis, MD, Radiology; John Anstey, MD, Obstetrics and Gynecology; Michael Bukstein, MD, Surgery; John Fitz, MD, Ophthalmology; Dennis Pyszczynski, MD, Thoracic; Thomas Highland, MD, Orthpaedic Surgery; Michael Chehval, MD, Urology.

Commission on Medical-Legal Affairs

The MSMA Commission on Medical-Legal Affairs will become more active this year. We hope to meet with representatives of the Missouri Bar Association in an effort to strengthen our relationship and develop initiatives that benefit both professions. The following issues were monitored by the commission during the last year:

(A.) **Interprofessional Code** - The Metropolitan Medical Society of Greater Kansas City, in conjunction with the Kansas City Metropolitan Bar Association, have agreed on a jointly-revised version of the interprofessional code. The Commission will be reviewing the state interprofessional code, as it has not been updated in several years. The code was established to provide guidance on matters where medical and legal professions commonly interact.

(B.) **Medical-Legal Symposium** - The fifth annual Medical-Legal Symposium was held September 16, 1995, in Columbia. This event is co-sponsored by the Missouri State Medical Association, Missouri Bar Association, Missouri Association of Osteopathic Physicians and Surgeons, and the Missouri Hospital Association. Approximately 50 physicians attended. The symposium was developed to address liability issues, patient confidentiality, and improvements in patient care.

(C.) **Advanced Directives** - The committee supports the promotion of the AMA/AARP/ABA advanced directives initiative. The Advanced Directives guide is an understandable, portable way to receive information on living wills and health care power of attorney.

Marc Taormina, MD, Chair; Edmond B. Cabbabe, MD; Darrel D. Domann, MD; Roger A. Francis, MD; Ted Groshong, MD; Joseph A. Corrado, MD; Kenneth J. Bennett, MD; Gus S. Wetzel, MD; William F. Snidle, MD; Grant A. Bever, MD; James Kline, MD; W. Scott Campbell, MD; Gregory H. Branham, MD

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MSMA Peer Review Consultant System (PRCS)

The MSMA is now operating the Peer Review Consultant System (PRCS) for use by hospitals or managed care panels which are in need of an expert opinion from an objective physician. Many specialists, even in metropolitan areas, know each other or are in direct economic competition. As a result, MSMA has created a statewide system to match requesting organizations which have a privileging or credentialing matter with a physician specialist from a different part of the state.

This program has received just a few requests to date, but MSMA envisions this demand to be increasing due to the highly competitive health care environment. This program will allow differences to be resolved by objective physicians outside of the courtroom.

Since MSMA is in business to serve its physician members, we have created the following memorandum to be signed by any physician being reviewed to ensure he or she is aware of the MSMA involvement.

PHYSICIAN CONSENT TO MSMA
PEER REVIEW CONSULTATION

I understand that I have a right to an impartial and objective review of my conduct, professional qualifications, and competence to carry out the clinical privileges in question. I agree to allow the Missouri State Medical Association to appoint physician reviewers who are not in direct economic competition with me and not prejudicial for or against me or the credentialing body which brings this adverse action.

I understand that the process will meet the requirements for fairness as outlined in the Health Care Quality Improvement Act of 1986 and that the confidentiality of the procedures are protected by Missouri Peer Review Statute RSMo 537.035.

Name____

Signature__________________________**Date**__________

Public Affairs Commission

The Public Affairs Commission was challenged with several public health and information issues during the 1995-96 MSMA calendar year. During that time, the Commission met via telephone conference call on Nov. 1, 1995 and Jan. 24, 1996 to discuss public relations programming, immunization programs, brochure dissemination, electronic communication, and broadcast and media training for physicians. The following are recommendations from the Public Affairs Commission for 1995-96:

1) Public Relations:

The Public Affairs Commission recommended that the MSMA Communications Department utilize a systemized communications plan to 1) reach the general public regarding MSMA's patient-friendly legislative agenda, public health concerns, and programs to members; 2) encourage local physicians to relay medicine's concerns to the general public through the formation of a statewide Speaker's Bureau; 3) form statewide Mini-Internship programs to involve physicians and media.

Commission members encouraged the Communications Department to implement this plan using public relations techniques such as monthly news releases, position papers, and features on members for print and broadcast media.

2) Immunization Programming:

The Public Affairs Commission recommended that MSMA continue to participate in the Statewide Immunization Coalition to serve, support, and promote special events for immunizations, including National Infant Immunization Week to be held April 21-27, 1996, and to continue to support the Missouri Children's Immunization Reform Act. The Commission recommended that MSMA continue to work with the Department of Health regarding funding for the development of a private sector immunization education and assessment program. It was also recommended that MSMA implement CHART directives concerning the dissemination of immunization information and encourage involvement into the VFC program. The Commission directed staff to research the education and assessment programs before committing MSMA resources.

3) MSMA's "A Woman's Choice: Treatment in Breast Cancer Options":

For over 15 years, MSMA has offered this brochure on the various treatments of breast cancer to appropriate medical clinics for patients' use. Since our last order in 1984 of 50,000 brochures, we have distributed 49,800. In November, Dr. Michael Perry, Professor of Internal Medicine at Ellis Fischel in Columbia, prepared an updated revision of the brochure. The Commission recommended a reprint of 20,000 copies to sell to appropriate medical outlets for $.15 each.

4) MSMA's computer connection to the Internet

The Commission discussed MSMA's current endeavor of an Internet membership service and the development of a Home Page through a proposal with Sprint Telephone. Members would be able to utilize email services and access the Internet's other information resources. Members would access this service through local dial-up numbers without incurring long-distance telephone charges. This service would be based on a subscriber fee to be charged monthly or yearly.

We appreciate the participation of the following Commission members:

Steve Bowlin, MD, *Liberty*, Chair; Diane Brukardt, MD, *Columbia*; Steve Halpin, MD, *Hannibal*; Ravi Mehra, Jr., MD, *St. Louis*; W. Mike See, MD, *Columbia*; Ann Peick, MD, *Poplar Bluff*; James R. Blaine, MD, *Springfield*.

Committee on Publications

The ninety-second volume of *Missouri Medicine* contained 20 scientific articles and 12 "Perspectives" articles. The journal contained several regular departments, including: Public Health Reports, Practice Management, Medical Legal Issue of the Month, Editor's Desk and President's Page. The monthly specialty quiz continued this year with Otolaryngology, thanks to the University of Missouri-Columbia's Department of Otolaryngology.

The *Missouri Medicine* covers changed format to represent content of cover stories reporting legislation, Board of Registration for the Healing Arts, women in medicine, St. Louis Medicaid HMO's, domestic violence, and Boone County physicians' mission to Tblisi, Georgia.

The reformed State Medical Publishers Network (SMPN), formerly State Medical Journal Advertising Bureau (SMJAB), was not able to establish enough revenue from national advertisers to support the organization. State medical journals have been directed to find local advertisers. Currently, MSMA is supporting an advertising sales representative from St. Louis who is working on a trial basis for commission.

A readership survey has been sent to 1,000 MSMA members to assess the value and direction of *Missouri Medicine*. Future changes to format, content and frequency will be made following the recommendations of this survey.

The Publication Committee and Editor, J. Regan Thomas, appreciate the contributions of the members and others who have filled the pages of *Missouri Medicine* with interesting, enjoyable articles.

The Committee also appreciates the Association's continued support of the Journal.

J. Regan Thomas, MD, Chair; Philip C. Anderson, MD; John S. Daniels, MD; John C. Hagan III, MD; Donald G. Sessions, MD.

Missouri State Medical Services, Inc.

Missouri State Medical Services, Inc. is a wholly owned, for profit, subsidiary of the MSMA. It was created by MSMA Council along with a twenty-four month fiscal note of $250,000. This note has expired and MSMS drew $210,000. The first $30,000 is in the form of common stock owned by MSMA and the balance is a note payable to MSMA of $200,000 counting interest.

MSMS has consistently advocated that physicians control clinical decisions. To that end Tom Bennett, MSMS Executive Vice President, has been actively involved for the past eight months in assisting Renaissance Healthcare Partners, Inc. of Kansas City to become an operating PDN (physician directed network) with a panel of more than 800 physicians.

MSMS will continue to act as an advocate for physicians; to assist in creating physician organizations; and promoting group, IPA, or physician organizations contracting with managed care organizations. It is only through such organizations that physicians can assume sufficient contracting risk which will allow them to also assume total clinical autonomy.

Board of Directors: Dan O'Sullivan, MD, President; Pat Mills, CPA, Secretary - Treasurer; Lent Johnson, MD; John Rollo, MD; Jeff Copeland, MD; Bill Shell, MD; Jerry Kennett, MD; Jerry Murrell, MD; Steve Buie, MD; Bill Dorzab, MD; Fred Hahn, MD

Report of the MSMA TV project

The highly acclaimed MSMA TV project concluded in February.

Since April 1995, MSMA produced over 130 two-minute medical reports for broadcast as part of local TV news with Regan Thomas, M.D. of St. Louis as the expert commentator. They have been aired on KSDK - St. Louis, KRCG - Jefferson City, KOLR - Springfield, and KCTV - Kansas City.

Because of the expensive nature of television productions, a plan was approved by MSMA Council to market this video project to the other state medical associations. Simultaneously, MSMA worked on securing a corporate sponsor who would pay production costs in return for advertising.

MSMA was not been able to secure a corporate sponsor to pay for production costs because of the uncertain level of distribution by other state medical associations and their ability to be successful in having television stations in their state air these segments.

Some of the organizations contacted to partner with MSMA include the AMA, Sprint, Mastercard, Visa, Marion, Procter and Gamble, Shering Plough, and Hallmark.

Plans are being developed to continue marketing the MSMA through the use of radio and public access TV.

Installation of the MSMA Alliance President Joan M. H'Doubler

As I stand before you, I am indeed grateful, humbled, but yet proud, to be given this opportunity to assist in leading our Alliance in the coming year. For you see, I BELIEVE in the Alliance.

Will Rogers once said: "To be a success you must: Know what you are doing, Love what you are doing, and Believe in what you are doing." An I DO believe in the Alliance!

I have seen the difference we make across our nation today, as more than 600 initiative in 39 states create awareness of family violence and provide support for its victims. I have seen the difference we make in our communities through untold volunteer hours, promoting health education and services with more than 3,600 Alliance health projects across America today.

And I have seen the difference the Alliance makes in our personal lives and relationships, as over 200 medical family support programs address well-being, the medical marriage, physician impairment, retirement, and coping with the changing dynamics of health care delivery today.

These differences are the result of goals reached through the guiding vision of Alliance leaders.

This year leadership will be a focus. FOCUS meaning Follow One Course Until Successful. That course IS the promoting of leadership. Leadership...to an extent, leadership is like beauty: it's hard to define but you know it when you see it.

The challenge of leadership was impressed upon me during AMA Alliance Leadership Confluence sessions. No where else in the world of volunteerism are leaders so well trained and motivated. It was here I listened to John Venetch, a disciple of Warren Bennis, whom he considers today's guru of leadership in America. Through the influence of both, I pieced together my simple basics of leadership.

Leaders do not set out to be leaders. They set out to live their lives, using all their skills, gifts, and energies in expressing themselves fully. And when the expression is of value, they become leaders.

Leaders have a vision, a sense of where they are going.

Leaders inspire trust.

Leaders know who they are, what their strengths and weaknesses are, and how to fully deploy their strengths while compensating for their weaknesses.

They also know what they want, why they want it, and how to communicate what they want to others, in order to get cooperation and support.

Leaders understand the needs of their followers and focus on common goals, and know how to achieve those goals.

And finally, leaders have a passion for the promises of life and the ability to express themselves fully and freely.

We an organization can either stifle or encourage our potential leaders – our membership – our most prized treasure.

The essence of leadership is

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Joan H'Doubler accepts the gavel and presidency of the MSMA Alliance for 1996-97.

Alliance President Nona Nan Chapman's Address to the MSMA House of Delegates

Nona Nan Chapman, MSMA President receives her Presidential plaque and gavel from incoming Alliance President Joan H'Doubler.

Good morning, Mr. Speaker, Dr. Hahn, Dr. Dickey, Delegates and Guests: Greetings from the Missouri State Medical Association Alliance.

Good news! Your Missouri State Medical Association Alliance is now a 501 (c) (3). This means that any contribution you or your spouse make to our state organization is deductible, including your dues.

Do you have a spouse? Is he or she a member of Medical Alliance? Ask me or any of our members present at this convention about Medical Alliance and we will share with you our pride as members. We will further share with you the report we receive as members of the Federation: county, state, and national.

When I was installed president a little over one year ago, I asked fellow Alliance members to "Take note, we shall never pass this way again. Therefore, do it now."

Take note, we have! In programs in our state dealing with health, safety, and medical education of our children. We took note of the poor ranking Missouri has had with regard to the immunization of our children.

We took these concerns along with others to our Missouri legislators in March when we gathered in Jefferson City for our annual Day at the Legislature.

Under the leadership of the American Medical Association Alliance, we have joined in support of violence prevention programs, in our media, in our streets, and, yes, in our homes. County Alliances are contributing their support to safe houses and abuse shelters. Attention to our Stop America's Violence Everywhere campaign was brought utilizing billboards, television, newspapers, speakers bureaus, and newsletters.

This year we are educating ourselves about abuse even in the best of homes. At Fall Conference we were updated on the Missouri State Medical Association Physicians Health Program by Mr. Robert Bondurant. Our two speakers at this convention will add more light on this all too often hidden and painful subject.

Support of volunteer training programs has long been a priority of the Missouri State Medical Association Alliance and this year is no exception. We sent representatives from seven counties to the American Medical Association Alliance Leadership Confluence this year.

At these sessions members were able to share with other counties across the country similar experiences relating to the membership recruitment, health projects, legislative concerns, and ways to raise money for health education and research through the

American Medical Association Education and Research Foundation. AMA-ERF funds assist Missouri's medical students. More support will be generated this evening as we gather to raise funds and have some fun at our annual AMA-ERF Benefit. If you do not have your tickets, we do have some for you at registration. Your attendance at this event is very important.

Breaking tradition adds responsibility, the responsibility for breaking this tradition rests here (pointing to her shoulders). It is my job to increase the attendance at this fund-raiser. At the beginning of tonight's benefit, it will be my pleasure to present our Missouri medical schools checks representing many hours of fund raising activity by your members of Missouri State and Missouri County Medical Alliances this past year.

Oralee Puckett and I humbly request your presence. Or, in the words of Oralee, "y'uns had done better be thar."

On behalf of the Missouri State Medical Association Alliance, I wish you a successful and productive 138th Convention. Thank you.

Continued from page 238

understanding one's self and the world; the key to that understanding is learning from one's own life and experience.

Let us make a commitment to provide our potential leaders with opportunities to learn through experience in an environment that permits growth and change.

For these members to succeed as leaders, and our organization to grow and flourish, let us encourage three basic ingredients of success: Ideas, Relationships and Adventures.

Ideas are the basic for change, yes, for reinvention and innovation. The development, encouragement, and the support of new ideas are important to us because they direct and determine our future. In an era when the only thing that is constant is change, new ideas are our lifeline.

Relationships have to do with outstanding people working in harmony and openness, where everyone feels empowered, where all members feel included and at the center of things, where they feel competent and significant, and where they realize there is such a thing as BELONGING over and above JOINING.

Adventure has to do with risk, with a bias toward action, with incessant curiosity, and a willingness to dare the impossible, to break old barriers.

Let us endow our members with self-confidence and a can-do spirit, an eagerness to face the challenges of our time, and the courage to expose their dreams, their hopes, and to pursue then until their visions become reality.

And as we create this organizational structure where Ideas, Relationships and Adventure abound, our numbers will grow, our membership increase.

Membership will continue to be a focus, a VITAL focus, one which will strengthen our bond as medical families undergoing incredible and profound changes. This bond we share will join us in the third and final focus...unity...and one unified voice. We, as federated Alliance members, county, state, and national, are further unified through a singleness of purpose...Stop America's Violence Everywhere, the SAVE Program, AMA Alliance's first-ever unifying health promotion. Let us create an atmosphere of unity, county and state, one with each other, as we fulfill our commitment to educate and participate in violence awareness and prevention.

N. CHAPMAN
S. MITCHELL

Nona Nan Chapman, MSMA President, Jean Wankum MSMA Alliance Immediate Past President, and Sandra Mitchell, AMA Alliance President-elect. Sandy will be installed AMAA President in June.

Every organization has the opportunity to undertake and achieve great things. We must be opportunity seekers, willing to cross new thresholds, and reach toward new horizons. And so we embrace the opportunity to develop three new programs this year, our year-round SAVE Program, bringing widespread attention to issues of violence; Medical Alliance Month, giving us an opportunity, as physicians' spouses, to annually celebrate throughout the month of March, how our health promotion efforts improve community health; while the third is the De Novo Program for our spouses of participants in the Missouri Physicians' Health Program. De Novo is sponsored by the Missouri State Medical Association as a key adjunct to its program for impaired physicians. De Novo means "fresh start" and signifies hope and confidence in the future.

In closing, I have great confidence in the future of the Missouri State Medical Association Alliance. My commitment to leadership of this organization is filled with hopes and dreams. I have faith that my vision will become reality. For you see, I BELIEVE in the Alliance. Belief is the knowledge that what we undertake we can accomplish...all things become possible. And so I challenge you:

Dare to risk your ideas;

Dare to risk your hopes and dreams;

Dare to pursue them until YOUR vision becomes a reality!

Thank you. MoMed

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Revenue and Net Income of Missouri HMOs, 1995 & 1994

Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

Missouri HMO Financial Data - 1995	1995		1994	
	Revenue	Net Income	Revenue	Net Income
Humana Health Plan	1,089,751,605	44,574,787	915,890,430	21,483,444
Truman Medical Center	157,019,860	12,524,379	157,201,868	20,979,038
Gencare Health Systems	281,513,108	12,142,591	246,070,601	22,350,318
MetraHealth of St. Louis	56,289,655	6,711,481	47,913,942	2,476,918
Good Health (BlueCare)	38,559,443	3,505,240	27,699,209	4,315,792
Humana Kansas City	174,019,842	2,485,697	170,349,760	3,151,347
Kaiser of KC	71,162,047	1,738,881	70,104,239	863,446
Medical Center Health Plan (Partners)	64,043,373	1,156,316	60,896,284	1,447,863
PHP of Greater St. Louis	228,387,613	696,007	150,553,421	1,577,734
MetraHealth of KC	11,964,433	596,614	10,189,962	(52,543)
HealthLink	10,476,300	330,585	4,337,848	(684,119)
CIGNA Healthplan of KS / MO	56,577,011	45,038	54,169,139	(4,653,980)
Group Health	210,214,011	39,803	200,890,738	426,177
HealthCare USA	13,858,766	3,825		
Citizens Advantage	27,692,209	(83,692)	24,836,265	(456,936)
BMA Selectcare, Inc.	4,577,962	(242,820)	8,929,188	231,143
Alliance for Community Health	7,431,756	(1,135,192)		
Principal of KC	74,480,124	(1,497,349)	42,749,840	685,626
HealthNet	10,751,030	(1,629,824)	6,236,896	(2,101,896)
Community Health Plan	2,990,886	(1,667,521)		
TriSource (BlueAdvantage)	68,945,040	(2,004,891)	45,952,985	539,231
HMO Missouri (Bluechoice)	102,447,208	(2,761,596)	95,224,175	8,542,394
Mercy Health Plans of MO	3,798,877	(3,686,021)		
Exclusive Healthcare (KC)	73,820,282	(11,748,641)	52,893,471	(4,804,248)
Prudential (Prucare of KC)	2,084,280,960	(12,591,605)	1,816,523,500	74,670,641

Source: Missouri Department of Insurance

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Estate Planning Primer

Alan J. Agathen, JD

This article is intended to provide an outline of the basics of estate planning, perhaps reinforcing information that the reader may have heard before. It will primarily focus on the benefits to the estate planner of a revocable living trust as a part of his or her plan.

To understand the potential benefits to be derived from a revocable living trust, it makes sense first to look at the problems with estate-planning alternatives. Most couples who pose questions about a revocable living trust have basic mutual wills in which they direct that, upon the death of the first spouse, all assets are to go to the surviving spouse; and, if the spouse is predeceased, the assets are to go to the parties' children. What is wrong with this?

To understand what is wrong with such a simple his/hers will, the reader needs to understand just a few basic principles of federal estate taxation:

- When a person dies holding assets in joint tenancy with a spouse, all property so held automatically vests in the name of the surviving spouse. One-half of the value of the assets so held in joint tenancy will be considered part of the estate of the first spouse to die for federal estate taxation purposes.
- There is no federal estate tax on assets left to a spouse.
- Each individual can leave up to $600,000 exempt from federal estate taxation. Therefore, *with proper estate planning,* a couple may leave up to $1,200,000 free of federal estate taxation.

In this context, then, what exactly is the problem with simple wills? In most cases I see, couples who have such his/her wills have all their assets in joint names. Upon the death of the first spouse, all those assets automatically vest in the second spouse. No probate will be necessary for those jointly held assets at the time of the first death. Additionally, as indicated above, there is no federal estate tax due on assets left to a spouse. The problem, then, comes, not at the time of death of the first spouse, but at the death of the second:

(a) If that second spouse dies still holding all those assets and the only estate-planning device is a simple will leaving everything to the parties' children, the estate of that second spouse will have to be probated with all the attendant delay and costs. (Each county in the state has a probate court. The function of the probate court is to marshal all the deceased's assets, pay all of his or her legally enforceable bills and then distribute his or her assets to the parties which he or she has designated, or in the absence of a will, to the parties who are the deceased's heirs-at-law, as determined by Missouri state law.) Most of us have friends, families or acquaintances whose estates have gone through probate and, therefore, know that it is a time-consuming process (during which time the estate assets are held "in limbo" and are not readily assessable to the family). Probate records, in addition, are public; i.e., anyone who is curious can request and view the probate file of any deceased to learn, for example, what his or her assets were and to whom they are to be distributed. Finally, there is the cost of probate: one may expect a diminution in value of one's estate of 5-10% from court costs and attorney fees. Avoidance of probate is, therefore, an obviously worthy aim of any estate planner.

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(b) Additionally, the surviving spouse will now own *all* the assets previously owned jointly by both spouses. Everything over $600,000 will be subject to a federal estate taxation. This estate planning did not preserve the $600,000 federal estate taxation exclusion (known as the "unified credit") for the first spouse to die (because everything went to the surviving spouse at his or her death). The parties have essentially insured that they will pay, needlessly, at least $193,000 in federal estate taxes to Uncle Sam and leave at least $193,000 less for their children.

(c) Finally, such an estate-planning scheme takes all control over the ultimate destination of a couple's joint assets out of the hands of the first spouse to die. That spouse dies leaving everything to his or her mate, assuming that the survivor will then see to it that their children are given the benefit of anything remaining upon the death of the second to die. In a great majority of cases, this is, in fact, what happens. That first spouse to die, however, has no assurance that his or her surviving mate will not join a cult or dissipate the estate with profligate spending, leaving nothing for the parties' children. Far-fetched? Perhaps. But remarriage is a more likely possibility, and the financial pressures of a new family may lessen what is left for the children of the first marriage. These may all be speculative scenarios, but the point is that the first spouse to die has completely lost any control over the ultimate dispossession of those monies if everything is left to the spouse.

How does the revocable living trust solve these problems?

First a few words about what a trust is. A trust is an arrangement in which a person transfers legal title of his or her property to a fiduciary, the trustee, who manages the property for the benefit of someone. In a typical trust, a person transferring the property (generally called the "Grantor") transfers property to himself or herself and the spouse for the benefit of himself/herself and the spouse; i.e. the same party can be the Grantor, the trustee and the beneficiary. The Grantor retains as much control, during his or her lifetime, as he or she would have had had the assets not been placed into trust: a revocable living trust is, of course, revocable and, if it were revoked, the trustee would retransfer the assets back to the Grantor. The terms of a trust are modifiable. Finally, assets can be transferred in and out of the trust at the direction of the Grantor.

A typical revocable living trust of a married couple would be to provide something along the following order: during the lifetime of both parties, the trustees (again, generally, the husband and wife) are directed to pay all the trust estate income to the Grantor. Upon the death of the first spouse to die, the monies will continue to be held in trust for the benefit of the surviving spouse. Generally all income generated by the first spouse's trust assets will be paid over and/or used for the benefit of the surviving spouse. (The second spouse, of course, continues to have the benefit of the assets which were allocated to his or her trust as well.) In addition to income, the surviving spouse will have a *limited* right to encroach upon the principal of the trust assets of that first spouse to die. Upon the death of the second spouse, the trust document will direct that the assets remaining in the trust of the first spouse to die will be distributed among the named beneficiaries (generally the parties' children); and the assets held in the trust of the second spouse will be distributed among those name beneficiaries at that time as well.

What has been accomplished?

(a) Assets held in trust do not need to go through probate. When the trusts are initially established, if the couple names husband and wife as co-trustees of each trust, upon the death of the first, the surviving spouse becomes sole trustee. (The trust document could alternatively name another family member or trusted associate to step in as co-trustee upon the death of the first to die.) Both trusts, i.e., husband's and wife's, will necessarily name a "successor trustee" who is to step in to manage the trust estate upon the death of the second to die. This successor trustee instantly holds title to the assets upon the death of that second spouse, and there is, therefore, no need to have the assets probated to transfer title to the name of that successor trustee. Probate is avoided with its costs and delays, and the parties' financial affairs never become a matter of public record as the trust need not be filed or recorded with any government agency to have effect.

(b) The revocable living trust preserves the $600,000 federal estate tax exclusion, the unified credit, for both husband and wife. When husband and wife initially sit down and set up their trust they will allocate assets so that both husband's and wive's separate trusts will separately "own" at least $600,000 in assets. Then when the first spouse dies, his or her trust estate as described above will not be transferred over to the surviving spouse. Rather, it will continue to be held in trust until the death of the second spouse and then will pass directly from the name of the first spouse to the beneficiaries (again, presumably the parties' children). In this manner, the entire estate is not "dumped" into the lap of the surviving spouse with his or her being liable for federal estate taxation on everything over $600,000, on his or her death, when that estate passes to the beneficiaries. In sum, the parties can pass $600,000 free of federal estate taxation from the estate of *each*, or a total of $1,200,000.*

(c) The first spouse to die retains control over how his or her assets are ultimately distributed. As noted, the trust will generally provide that the surviving spouse has the right to receive the income of the trust estate assets of the first spouse to die; but once that first spouse has died, no changes can be made in how he or she has directed the estate assets to be distributed after the death of the second spouse to die. (The surviving spouse can, of course, completely alter or even revoke his or her trust during his or her lifetime.) The estate planner has great flexibility in determining how and when the children are to receive the estate's assets following the death of the second spouse. Such flexibility is generally not available in a simple will. In a trust, however, the successor trustee, upon the death of the second spouse could, for example, be directed to continue to hold the children's portions in trust (giving them the income from their respective portions starting at age 21, for example), but not distributing the principal of the children's respective trust shares until they reach more advanced ages, and then paying the principal out in stages, e.g., one-third at age 25, one-third at age 30, and one-third at age 35. (This author has seen trusts in which the monies were not to be paid out to the parties' children, for better or worse, until they were in their 60s.) The trust could also make provisions for the children of any deceased child, directing, for example, that the grandchild's monies are to be held in trust with specific provisions for expenditures for education, health, welfare, etc. There is no end to the complexity and ingenuity that the estate planner may wish to utilize in this regard. Again, generally, that type of flexibility is not available to an estate planner with a simple will.

An additional benefit with a revocable living trust is that the Grantor (i.e. the person making the trust) may provide that if he or she becomes incapacitated, the co-trustee (generally the surviving spouse, if alive) or the successor trustee (if the spouse has already predeceased) may step in to take over administration of the estate before the death of the Grantor. This avoids the necessity for family and friends to apply to the probate court to have a guardianship and conservatorship established to permit them to administer the assets of the incapacitated Grantor.

Interested individuals should also be aware that they may reduce their estate by initiating a gifting program, if only informally. An individual may give up

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* The parties could accomplish through the use of simple wills, though probably less palatably: if the parties had all their assets divided into separate names, the will of each spouse could provide that upon his or her death, the first $600,000 in his or her name went directly, at that point, to the parties' children, with the balance going to the surviving spouse. The problem with this is that the surviving spouse would not get the benefit of that $600,000 during his or her remaining lifetime. In addition, most couples do not own assets, or the bulk of their assets, in separate names. They own most assets jointly and if assets are owned jointly, they vest automatically and instantaneously, upon the death of the first, in the surviving spouse. In that case there is nothing to pass under a will.

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to $10,000 per recipient in every calendar year; a couple may therefore gift $20,000 per recipient each year. Consideration of whether to engage in such gifting would require thorough analysis of the couple's continued life expectancy, anticipated income, expenses and probable financial needs during the balance of their lifetimes.

Irrevocable Insurance Trust

Another attractive estate planning device is the irrevocable insurance trust. Generally, this trust permits a party to funnel insurance proceeds into a trust, (the distribution terms of which may be identical to those of his or her revocable living trust) with those insurance proceeds being wholly excluded from the person's gross estate for federal estate taxation purposes. Such a trust is, of course, *irrevocable* but, if it is funded through term insurance, the Grantor may, if he or she chooses, merely stop paying the premium on the policy. The irrevocable insurance trust can be funded with a second-to-die insurance policy relatively cheaply, thus providing assets with which to satisfy any federal estate taxes on the couple's other assets which are subject to taxation upon the death of the second spouse.

Due to space limitations, this article has merely scratched the surface of estate planning. Each estate plan must be custom-made, and consultation with a financial/legal advisor is recommended.

The Author

Alan J. Agathen, JD, practices law in Clayton, Missouri. He has a general practice, focusing on health law. He is a member of a subcommittee of the Health and Hospital Law Committee of the Missouri Bar Association and of St. Louis Area Health Lawyers Association.

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Seasonal Allergic Rhinitis

Paul R. Cook, MD

Seasonal allergic rhinitis is the most well understood of the types of allergic rhinitides. The disease is characterized by sneezing, itching, rhinorrhea, and nasal congestion upon exposure to pollen allergens in susceptible individuals. These symptoms can cause considerable misery in affected patients. Recent advances in the diagnosis and treatment of this disorder as well as new insights into the pathophysiology of allergic rhinitis enable practitioners to provide more effective therapy.

Although less common than perennial allergic rhinitis, seasonal allergic rhinitis (SAR) is the most commonly recognized form of inhalant allergy. As the diagnosis implies, SAR is an inflammation of the nose caused by a seasonal allergic reaction. In this case, the reaction is caused by pollen. Pure seasonal pollenosis occurs in only 10% of patients with allergic rhinitis; however, this type of SAR receives the most attention from the media, and to some degree, pharmaceutical companies. SAR is the most fully understood form of allergy, and has been recognized for over 150 years.[1]

The symptom complex of sneezing, nasal congestion, conjunctivitis, and itching of the skin was first described by Jonathan Bostock of Liverpool and London in 1819. In actuality he described his own symptoms, which occurred from the middle of June to the end of July. These symptoms were originally attributed to the effect of sunbeams on the grass. He called the condition "summer catarrh."[2] In 1828, after years of observation, he associated the condition with the effluvium of freshly cut hay, and renamed the condition "hay fever."[3] Today, this term still enjoys frequent use.

Several investigators commented on the condition thereafter. However, it remained for Merrill Wyman of Cambridge, Massachusetts, to clearly identify pollen as the causative agent of hay fever. He published his classic description of hay fever in 1872.[4] In the following year, Charles Blackley of Manchester, England demonstrated the effect of applying grass pollen to theexcoriated skin of a sensitive patient.[5] The result was a raised wheal surrounded by erythema that "itched intensely."

In the 1930s, A. Thommen developed a set of criteria used to determine if a particular pollen is allergenic. These criteria have since become known as Thommen's Postulates, and consist of the following:

1. The plant must be seed-bearing. Only seed-bearing plants produce pollen.
2. The pollen must be able to produce allergy symptoms.
3. The pollen must be wind-borne (anemophilous).
4. The pollen must be produced in LARGE quantities.
5. The pollen must be buoyant to be distributed over a wide range (15 to 50 micra in diameter).
6. The plant producing the pollen must be widely and abundantly distributed, or close to human habitation.

Patients habitually blame their symptoms on profusely flowering, brightly colored plants. The vast majority of these plants are insect-pollinated (entomophilous), and do not produce allergenic pollen. The drab, non-colorful plants cause the most problems. A good example is an oak tree. These trees (and their pollen) fulfill Thommen's Postulates.

Continued on page 232

Table 1. Symptoms of Allergic and Infective Rhinosinusitis

- Suggesting allergy:
  - Itching mucous membranes
  - Clear rhinorrhea
  - Other remote symptoms of allergy
    - Asthma
    - Eczema
    - Food intolerance

- Suggesting infection:
  - Purulent, thick mucus
  - Other remote symptoms of infection
    - Sore throat
    - Purulent sputum production

- Common to allergy and infection:
  - Nasal congestion
  - Fluctuating rhinorrhea (thick to thin)
  - Sneezing
  - Headache/pressure

Table 2. Specific Tests for Allergy

- Skin tests:
  - Prick tests
  - Intradermal tests
  - Quantitative intradermal (End-point titration)

- In vitro tests:
  - Radioallergosorbency test (RAST)
  - Enzyme-linked immunosorbency assay (ELISA)
  - Pharmacia CAP
  - Chemoluminescent/spectrophotometric
  - Total IgE

- Mucosal challenge tests:

- Challenge feeding tests:

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Symptoms of SAR are caused by tree pollens in the spring (late February to May), grass pollens in the summer (May to June), and weed pollens in the fall due to ragweed (mid-August to the end of September – before frost). In many areas such as Missouri, there is considerable overlap in the pollen seasons such that April is a tree/grass pollen month, and August is a grass/weed pollen month. Depending on the weather conditions, pollen may be in the air in mid-Missouri for 10 months out of the year.

With advancing age, corresponding to the number of seasons of exposure to seasonal allergens, susceptible children develop classic symptoms of paroxysmal sneezing, rhinorrhea, and pruritus, often accompanied by itchy and watery eyes. By the time the individual reaches late adolescence or young adulthood, symptoms are often quite pronounced and can cause significant morbidity. This morbidity has a major impact and should not be trivialized. The loss of productivity and the expenditure of health care dollars is staggering.[6] The morbidity of SAR may be further increased by the development of complications such as sinusitis (Table 1), eustachian tube dysfunction with or without otitis media, nasal polyposis, craniofacial abnormalities, and bronchial asthma.

The most useful diagnostic procedure in the evaluation of SAR is the history. The development of symptoms should correlate with exposure to pollen during the appropriate season. Most plants pollinate between 10 am and 3 pm, which is a useful fact in history taking. Classical clinical diagnostic signs are allergic shiners, Dennie-Morgan lines of the lower eyelid, allergic salute and other facial gestures, supratip nasal crease, pale edematous nasal mucosa, copious clear watery rhinorrhea, and conjunctivitis. These signs as well as the characteristic symptoms of allergic rhinoconjunctivitis result from the effects of chemical mediators which are released from mast cells, and cytokines which are released from infiltrating inflammatory cells.

Since this disease is IgE-mediated, in-vitro and in-vivo allergy diagnostic tests are very useful (Tables 2, 3). Nasal smears or nasal cytograms can be helpful as screening procedures. A typical nasal smear in a patient with SAR should reveal abundant eosinophils and some neutrophils. From a practical standpoint, most cases of SAR are easily diagnosed from the history, and can be quickly confirmed by a few properly

Table 3. University of Missouri Pediatric ImmunoCAP Panel (Pharmacia CAP)*

Milk
Egg white
Corn
Wheat
Soybean
Alternaria tenuis
Cladosporium herbarum
D. farinae
D. Pteronyssinus
Cat dander
Dog epithelium
Cockroach

*multi-antigen weed, grass, and tree pollen panels may be added as clinical situation dictates.

selected and administered skin tests. Skin prick tests and/or intradermal tests are used most commonly.[7]

Patients presenting with mild to moderate symptoms of SAR will usually respond to allergen avoidance and symptomatic treatment with the newer non-sedating antihistamines (Tables 4, 5), decongestants, topical nasal steroids (Table 6), and/or topical cromolyn or nedocromil (Table 7). Research has shown that using anti-allergic pharmaceutical preparations prophylactically before seasonal exposure achieves excellent control of the symptoms of SAR by preventing mediator release. Patients refractory to these measures (i.e. medical treatment failures) may need allergen-specific immunotherapy.[7,8] These patients often have severe, debilitating symptoms, and multi-antigen, multi-seasonal disease. Occasional bursts of oral steroids may be beneficial to these patients if they are particularly

Continued on page 234

Table 4. Nonsedating Antihistamines

Alkylamines	Acrivastine[1]	8 mg x 3
Piperazine	Cetirizine[2]	10 mg x 1
Piperidine	Astemizole	10 mg x 1
	Ketotifen[3]	2 mg x 2
	Loratidine	10 mg x 1
	Terfenadine	60 mg x 2
Miscellaneous	Azelastine[3]	Oral or topical x 2
	Levocabastine	Topical x 2
	Ebastine[3]	10-20 mg qd
	Mizolastine[3]	10 mg x 1

[1] Semprex-DTh Adams Pharmaceuticals.
[2] ZyrtecTh Pfizer Pharmaceuticals.
[3] These are investigational drugs.

Table 5. Pharmacological Actions of New Antihistamines: Second-Generation H-1 Receptor Antagonists

Decreased vascular permeability
Decreased pruritus
Smooth muscle relaxation
Decreased cyclic guanosine monophosphate
Decreased prostaglandin generation
Increased A-V nodal conduction time
Inhibited activation of airway vagal afferents
Decreased hypotension, flushing, headache, and tachycardia
Decreased release of inflammatory mediators
Derecruitment of inflammatory cells
Decreased early and late phase response to antigen

Table 6. Topical Nasal Steroids

Preparation	Delivery	Doses/day	Margin
Dexamethasone	FHP	3	1+
Beclomethasone	FHP or Pump (AQ)	2	5
Flunisolide	Pump	2	3.5
Triamcinolone	FHP	1	8
Budesonide	FHP or Pump	1 or 2	17.5
Fluticasone	Pump	1	25
Flucortin	Powder	3	?

*Multiple of recommended maximum daily dose which results in a significant risk of hypothalamic pituitary axis (HPA) suppression.

Continued from page 233

miserable. Immunotherapy is usually preferable to repeated use of oral or injected steroid preparations (Table 8).

Immunotherapy is a very valuable tool in the treatment of allergic disease, and may prevent long term complications and sequelae in allergic rhinosinusitis.[8] Conceptually, allergen specific immunotherapy causes the immune system to switch from the pro-allergic T-helper lymphocytes (TH-2 cells) to the anti-allergic T-helper lymphocyte (TH-1) effector lymphokine profile.[9]

Immunotherapy has the following methods of action: 1) gradual increase in allergen specific IgG antibodies as immunotherapy is continued; 2) decreased IgE production during prolonged immunotherapy; 3) alteration of the relative activity of T-helper and T-suppressor lymphocytes; 4) prevention of the rise in chemotactic factors that normally occur during allergy season, and 5) demonstration that immunotherapy decreased antigen-induced eosinophil migration into the nasal cavity.[7]

Successful immunotherapy depends on several factors: the patient should have symptoms of allergic rhinitis or asthma after natural exposure to a specific aeroallergen; the patient should have skin tests or in vitro evidence of IgE antibody to a potent extract of a specific aeroallergen; and, the patient should receive a series of appropriate doses of an extract of the specific aeroallergen that is of a defined potency. High doses of antigen are required to achieve optimal results.[7,8]

Table 7. Summary of Properties Mast Cell Stabilizers

Examples:	Cromolyn, nedocromil
Action:	inhibit degranulation of mast cells and liberation of inflammatory mediators.
Common routes of administration:	topical
Side effects:	local itching, burning, and irritation (rare); serum sickness (extremely rare)
Drug interactions:	may slightly decrease the response to the methacholine challenge test
Common indications:	allergic rhinitis, allergic bronchitis with bronchospasm, and EIA(B) (prophylaxis and treatment)
Potential misuses:	misdiagnosis of allergy, inadequate contact with mucosa (polyps, etc)

Table 8. Management of Allergic Rhinosinusitis

- Avoidance
- Mast cell stabilizers
    - Cromolyn
    - Nedocromil
- Antihistamines/decongestants
- Corticosteroids
    - Intranasal
    - Systemic
- Immunotherapy

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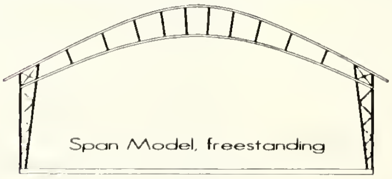

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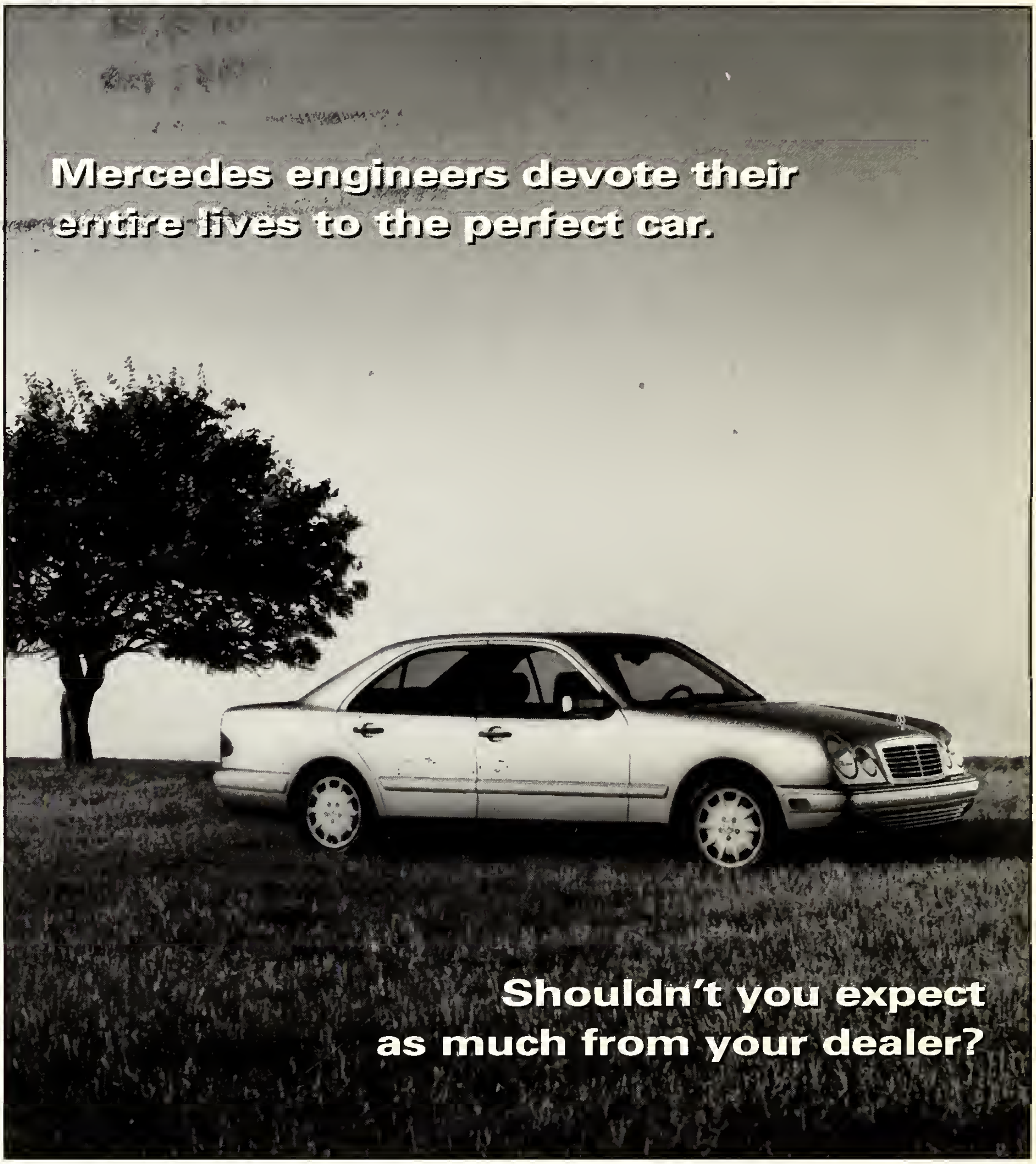
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On the Cover: Walter A. Schroeder, Jr., DO, MD, FACS, a practicing Otolaryngologist in Cape Girardeau, Missouri, took this photo at the area's annual balloon festival.

"How Are We Doing, Now?"

J. Regan Thomas, MD, Editor

A few months ago I discussed through this column the desire to have feedback for the *Missouri Medicine* editorial staff. You may remember that I paraphrased former New York Mayor, Ed Koch's slogan, "How are we doing?" A survey was developed to help answer that question and was originally presented to the MSMA Council as a select straw poll. Those results have previously been reported. We then surveyed the membership at large and now that data has been tabulated and is available for review. On behalf of the *Missouri Medicine* editorial staff, thank you for taking the time to complete the survey and provide your opinions about the journal.

We asked you to indicate how you typically read the journal. The majority (53.74%) of readers scan through the journal each month, while another 23.79% read looking specifically at topics of interest. Less than 1% (.88%) never read the journal although nearly 2% (1.76%) put it in their "to read later" pile. If your "pile" is like mine, that may be the black hole of medical information from which no light or matter ever reappears. Good intentions should not go unrewarded however.

We fared pretty well when compared to reading habits of other popular journals published on a national basis, i.e. *New England Journal of Medicine* (19.38% always read), *JAMA* (30.40% always read), or *AMNews* (34.36% always read). Not surprisingly the individual specialty journals were the most well read with 83.7% of you stating that you always read those publications. I will momentarily digress to say as editor, the information tells me two things. First, that *Missouri Medicine* is useful and continues to provide a service to our members. Second, we should not try to compete with the specialty journals. That is, publish information that has Missouri connections and perhaps even in our scientific articles focus on topics with a Missouri related data base rather than deal with papers better published in the specialty journals.

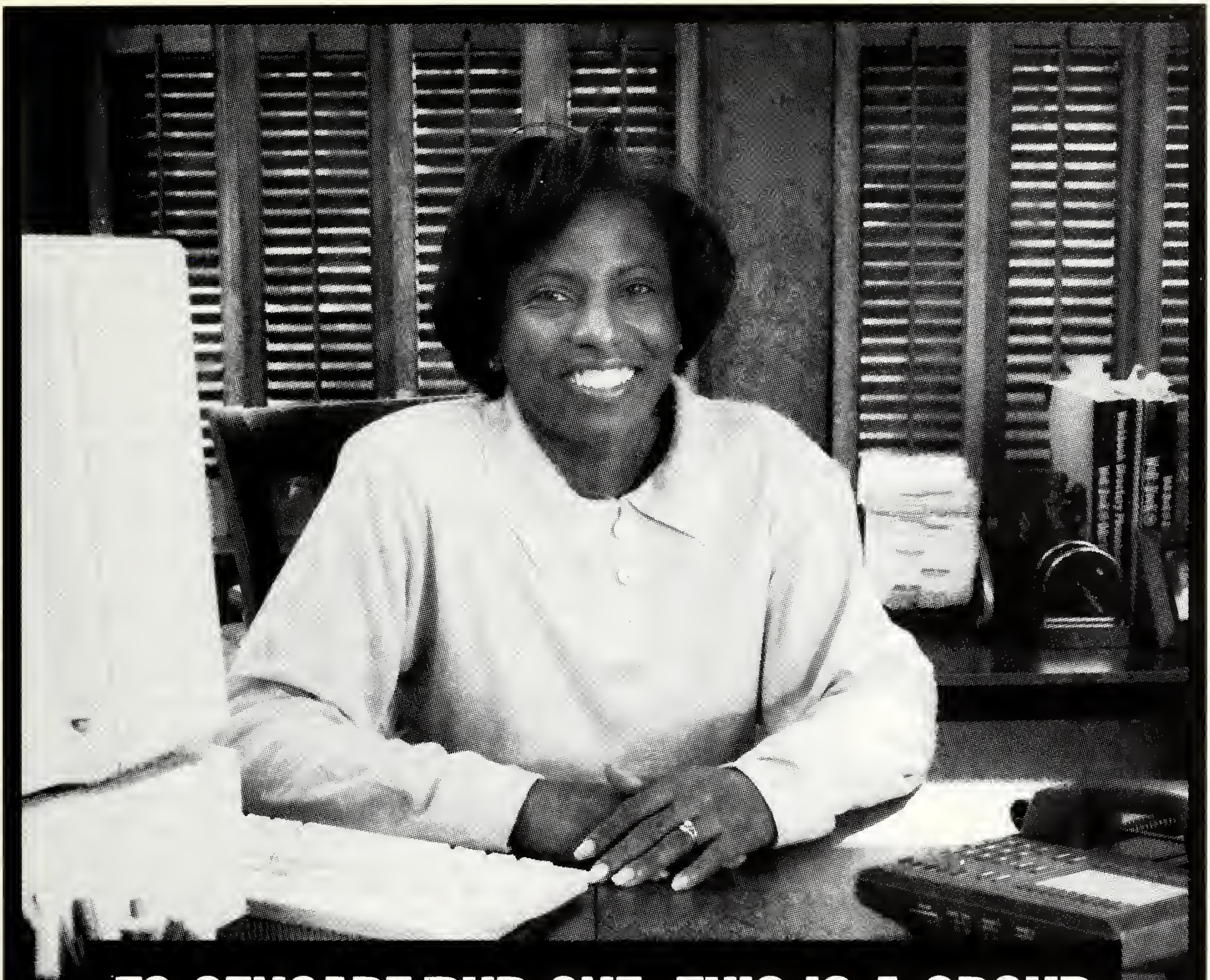
Missouri Medicine contains a number of regular sections. We asked you indicate how often you read each of the sections. The "Medical-Legal Issues" section was on top with 46.74% indicating that they either always or frequently read that section. The "Editor's Desk" was second, I'm delighted to say, with 40.98% and just edging out the "Scientific Articles" which garnered 39.64% in the always or frequently read category. The "President's Page" came in next with 35.68% marking these categories. I can hardly wait to joke with the MSMA President Dan O'Sullivan about the relative popularity of the "Editor's Desk" page and the "President's Page." The "Practice Management" and "Specialty Quiz" sections were next with 35.24% and 34.37% respectively. The "Perspectives" section and "Public Health Reports" seemed to vary depending on the topic.

We also inquired about how interested you would be in reading articles and features on other topics in future publications. Medical Economic issues headed the list, followed closely by Legislative (State and National) articles and Medical Ethics features. Cartoons were relatively low on the list of possibilities, perhaps indicating that as a group we are in no mood to smile.

We changed the covers of *Missouri Medicine* in 1995 from fine art (my preference) to graphic art reflecting the content of cover stories. A plurality (44.49%) of you prefer cover story art. Those of us with more refined tastes may have to look elsewhere for aesthetic fulfillment.

Finally, we asked the membership how often *Missouri Medicine*

Continued on page 265



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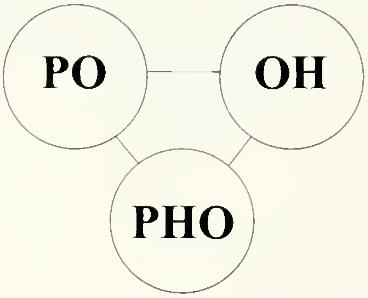
The Physicians' Partner

Daniel O'Sullivan, MD, MSMA President

Pooh on the PHO.

As physicians attempt to acclimate themselves to the changes in medicine, particularly in managed care, most analysts of the situation recommend partnering in some manner in order to strengthen the negotiating power of the individual, decrease overhead expenses and create a professional environment in which the individual can compete with his or her competitors. The identification of the proper partner for any physician might be association with an existing group of physicians, partnering with a hospital, association with an existing managed care organization or insurance company, or co-sponsorship with a business venture primarily unrelated to health care. In this discussion we will concentrate on physicians partnering with hospitals.



Throughout most of their careers physicians, particularly surgical specialists, have spent most or all of their days working in hospitals. For some this might be a single location and for super specialists, it might include many hospitals in a large community. Most of us have taken this for granted and have accepted a relationship with the hospital which, for the most part, has been friendly. The physician and the hospital have worked together and, through a friendly cooperation, have been interdependent on one another for existence. Physicians need the hospital as their work place and the hospital needs physicians for admitting patients. It seems like a natural alliance. With the advent of managed care in our community, a new relationship has evolved which is at least distasteful and sometimes confrontational. Suddenly it seems the desire to dominate permeates the boardroom atmosphere at many of our hospitals. No longer is quality the key word, nor cost, but rather, control. The Trojan horse with "peaceful coexistence" tattooed on its forehead is called the PHO.

The physicians hospital organization (PHO) in theory should consist of a physician organization (PO) and a hospital organization (OH) which join together in a joint venture with equal participation resulting in a health care system which will provide many existing services provided by both sides at a high level of quality and low level of cost – now referred to in the managed care glossary as "value."

The failure of physicians to organize and negotiate as a true body results in a schizoid response to the invitation of the hospital to partner as a PHO. To be specific, the operating structure of the hospital serves as a skeleton of the PHO and the provider arm of that organization is implanted into the skeleton. The PHO implies that physicians will have equal voice and 50% representation on the board. In most circumstances, the chairs filled by physician numbers are either selected or approved by the hospital portion. These seats might be filled by physicians who are hospital employees or hospital-appointed offices or merely affirmative friends. On the hospital side, the board seats are filled by knowledgeable, high-level administrators and the filler seats on the board might be occupied by the volunteer who runs the candy shop. The result of this is that the physicians really have no equality in board voting. Some organizations include in their bylaws differential voting such that a majority of the hospital votes must approve certain types of decisions.

The attitude may seem paranoid on the surface but if the intent of such an organization is to allow physicians medical decision making, utilization review, credentialling and approval of equipment such as suture material, instruments and drapes in the operating room, then the structure should be set up so that the equity of the physicians equals the equity of the hospital and the physicians should choose their own representatives as does the hospital with equal vote for all. As previously mentioned, however, the key word is control.

An older clinician might think that the goal of the hospital and the goal of the physician are the same; that is, provide our patients with the best possible care at the lowest possible cost while permitting the hospital to manage its business and the physicians to practice their profession. It seems a shame that such an equilibrium is so hard to reach. Unless we stop arguing and fighting for control and until physicians can work together in some sort of PO, such a compromise will be impossible to reach. If that happens, it will be POOH on the PHO. **MoMed**

EDITOR'S DESK - Continued from page 262

should be published? The majority of you (57.71% preferred monthly or at least bimonthly publication. One of you (0.44%) responded that the journal should "never" be published. We would like to feature the rascal's photo but I assume he or she wouldn't see it anyway. You can't please them all I suppose, but we are glad that the journal seems to be on the correct path for most of you.

We also received many useful suggestions that we will begin to incorporate into the journal. I thought the suggestion to feature "How I do it" articles on techniques or procedures of wide interest by experienced practitioners was a great idea. I also liked the suggestion to include highlights or updates from component county or metro societies. Many of you mentioned that you appreciate having a Missouri-oriented publication. The appreciation is gratifying and we will continue to do our best to deserve your support. *Missouri Medicine's* goal is always to serve you, the MSMA membership. Don't forget to periodically let us know, "How are we doing, now?" **MoMed**

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Focus on Health Care for the Medically Under Served

Will Ross, MD, Associate Dean and Director of the Office of Diversity
Washington University School of Medicine

In this age of justifiable fiscal conservatism, Americans have lost patience with our unsuccessful efforts to rein in our staggering federal debt. Our three major Federal expenditures are: 1) Interest on the Federal Debt, 2) Defense Spending, and 3) Entitlement programs, including Medicare and Medicaid. However, it is the latter that has received the greatest media interest and public demands for reform.

Health care costs are skyrocketing: the Department of Health and Human Services estimates that without reform health care spending in year 2000 will amount to $1.4 trillion, 18% of the GNP. The basic question now is who stands to lose more in the move to contain health care cost? I submit that the poor and underprivileged will suffer disproportionately, and that the final cost to society will ultimately increase.

Traditionally, poor inner city residents have relied on hospital emergency rooms and public outpatient clinics for care. Over the years, federal budget cuts have forced inner city hospitals and clinics to close, with most of the remaining public hospitals facing severe financial crises. Medical care for inner city poor and uninsured patients is customarily relegated to public facilities that are grossly under-funded and suffer from deteriorating physical plants, overcrowding, long waits for emergency treatment, staff shortages, and outdated equipment.

The consequence is a segregated two-tiered health care system: indigent and uninsured patients receive treatment at under-funded public hospitals, those with private insurance receive care at more modern, better-equipped, and better-staffed private hospitals.

The irony is that only a few urban residents receive basic health care. In addition, there is a common misconception that **all** inner city residents meeting federal poverty guidelines have equal access to health care. On the contrary, only 42% of urban residents qualify for Medicaid under those guidelines.

Those patients that do have access to medical facilities find their care is expensive and inpatient focused, because of their lack of preventive and primary care. As their medical condition deteriorates due to delays in diagnosis and treatment, they in turn require even more expensive and long-term treatment, outstripping the resources of most public hospitals.

Today, when we speak of health care reform to address the aforementioned problems we at times confuse reform with the practice of managed competition, which focuses more on cost containment than true reform. As concerned physicians we must support the concept of focused and objective health care reform, which embraces the concepts of: 1) Universal coverage, 2) Comprehensive preventive and primary health care coverage, 3) Reduced financial barriers, and 4) Improved accessibility to health care.

Although it may not be politically correct to debate universal health care coverage, we must realize that ultimately it is more cost effective. The Congressional Budget Office estimated (using 1989 statistics) that with the market reform plan the change in national health care spending could increase by $30 billion, whereas under a single-pay the spending could increase by $7.4 billion.

It is prudent at this time to examine the basic premise of **whether we view health care as a right or a privilege**. It is apparent upon legal review that health care is not among the enumerated "rights" in the Constitution. We should be equally cognizant that entitlement programs such as Medicaid and Medicare, which are subsets or a "privilege" shared by members of our society who meet statutory guidelines for coverage, could by Congressional mandate be repealed, thus abrogating the entitlement privilege. We should therefore take the approach that, regardless of individual beliefs on rights and privileges, health care should be **accessible** to all citizens. The U.S. and South Africa stand alone among industrialized nations in not ensuring uniform access to health care for its populace. It is on this basis that the following tenets should be considered:

1. Supporting the provision of universal access to health care for the medically under served with safeguards at the Federal level.
2. If Congress approves Medicaid/Medicare Block Grants then the States must maintain appropriate safeguards to protect children and pregnant women.
3. Health care committees should be convened to review local health care outreach programs to allow replication of successful programs throughout the area. The recent Archbishop's Committee on Community Health identified clear gaps in outreach programs affecting low income and uninsured individuals. It is practical and cost effective to expand and secure funding for several safety net programs already operative, including the Ryan White AIDS program, Health Care for the Homeless, Family Planning Programs, Sickle Cell and Asthma Intervention Programs, and Home Health Programs.
4. Community boards should be established to oversee quality of care offered by the new network of Health Maintenance Organizations in Missouri. In a manner similar to the United Hospital Fund of New York, the oversight board could study the impact of managed care on health care outcomes, utilization, and quality of care.

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5. Neighborhood health clinics and acute care facilities in the under served region of Missouri should develop contractual arrangements to ensure that health care resources are equitably distributed.
6. We must support expansion of the Medicaid 1115 Waiver. Currently 50% of potential Medicaid recipients never attain eligibility.
7. We must develop and support forums that permit substantive discussions between State and local health care officials, elected officials at the State, City and County level, community and civic leaders and officials at not-for-profit health care organizations on maintaining a health care safety net.

There is no greater disservice we can do as physicians than to remain silent on the inequities in the current health care delivery system. Universal access to health care may not be truly a "right" but it should receive the highest priority in an egalitarian society. MoMed

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Is Health Care Really a Right?

J. Lynn Teague, MD, Assistant Professor & Director of Pediatric Urology
Children's Hospital at University Hospital & Clinics, Columbia

America is a society driven by personal rights. We take justified pride in a Constitution that extends civil rights to all citizens. Our system provides rights that only can be dreamed of by many people in the world. Voting rights, freedom of religious expression, and freedom of speech are only a few of the many rights that we enjoy and that make us the envy of much of the world.

In addition to the many rights clearly spelled out in the Constitution, we now have a whole new class of rights. Rather than being subjected to the rigorous approval process required of constitutional amendments, this class of rights has been produced by legislation or judicial fiat. Because the amendment process and its inherent requirement for a broad consensus have been circumvented, these rights often lack the complete support of the American people. The classic example of this new class of rights is abortion. Although the American people are deeply divided on this issue, judicial decisions have established this procedure a right afforded by the Constitution. As with all constitutionally protected rights, the power of the federal government can be used to ensure its availability. As the legislature and judiciary become more active, more rights appear. We now hear of Medicare rights, social security rights, welfare rights, education rights, veterans' rights, etc. The list seems to grow daily.

To the ever growing list of "rights," many would now like to add the right to health care. Dr. S. D. Madduri made an eloquent plea, in an editorial in the April issue of *Missouri Medicine,* for the establishment of health care as a basic civil right. It is difficult to argue against such a seemingly humanitarian concept, but there are reasons to be wary of agreeing with such an idea.

It seems clear that much of what are now called "rights" are no rights at all, but entitlements provided by the government tax dollars. Rights as outlined in the Constitution are not provided by government, but are rather protected by it. They are inherent to individuals as a result of their position as citizens in the society. The government must provide the opportunity for an individual to exercise these rights, but not necessarily the means. You have the right to free speech, but the government does not buy you a megaphone. You have the right to practice your religion, but the government does not build you a church.

History shows that when government is involved in a project, complexity and costs will generally grow and freedom will be lost. Examination of Medicare clearly demonstrates this. When originally proposed by President Johnson, the projected cost of the entire program was estimated to be $9 billion. It is now at least ten times that and threatens to bankrupt the federal government.

In response to this, there are now thousands of pages of rules and regulations mandating what can happen within the once private doctor-patient relationship. A self-sustaining, multimillion dollar bureaucracy has grown to administer these regulations. A new industry of Medicare HMOs has arisen to control costs. As with every HMO, costs are controlled by limiting patient access to certain services. Ironically this is just the opposite of what Medicare was originally intended to do.

Continued on page 270

Continued from page 269

Beyond the practical problems associated with government involvement in any private enterprise is the more philosophical question of personal responsibility and self reliance. One of the heart rending stories in Dr. Madduri's article regarded a young family man who allowed himself to be without insurance coverage for several months while he changed jobs. Under current law, he most likely could have maintained his insurance from his previous employer by paying the full premium until his new policy became effective, but he chose not to avail himself of this. He developed a testicular tumor during this time and required extensive treatment. Care was delayed because of his lack of resources and his family was financially devastated. Would paying for the insurance have been a financial hardship? Probably, but it almost certainly could have been done with some planning and foresight. Had the insurance been in force, the story would have a much happier ending.

Before I am labeled as a cold, heartless physician, let me emphatically state that I believe all Americans should have access to adequate health care and I realize that the costs of many services, especially surgical procedures, are beyond the means of most individual families. I must also state that universal coverage mandated by a created "right" and provided through yet another government agency is not the answer. As we allow the government to control more and more of our resources we essentially become wards of the state, free of any personal responsibility, relying on the government to meet our needs. A citizen's rights should free him from government dependence, not enslave him to it.

There are viable alternatives for providing health care that do not involve more government payouts. All physicians are called to serve to the poor, but many have been forced to forgo charity care because of downward reimbursement pressures, malpractice fears, and spiraling costs. Perhaps we should allow doctors and hospitals to deduct such care from their taxes. Medical savings accounts have been demonstrated to be effective in both decreasing costs and increasing access. Although current law prohibits their tax deductibility (unlike traditional health insurance, the cost of which is fully deductible by corporations), they have been successfully used by several companies. There are several organizations, such as samaritan ministries, whose members share medical costs monthly. Members pay cash for routine services and as such often receive significant discounts. Major medical costs are reimbursed by contributions from other members. Monthly costs are generally less than one half of traditional insurance policies in large part because members commit to a healthy life-style. These are only a few examples of ideas that might help provide care to all Americans.

I am not so naive as to believe that a few simple measures will solve health care's problems. I do believe, however, that as physicians we are called to care for all people, regardless of financial status. Let us commit ourselves to that goal using the ingenuity and generosity of the American people rather than the heavy hand of government. MoMed

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Radiology Quiz #5

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

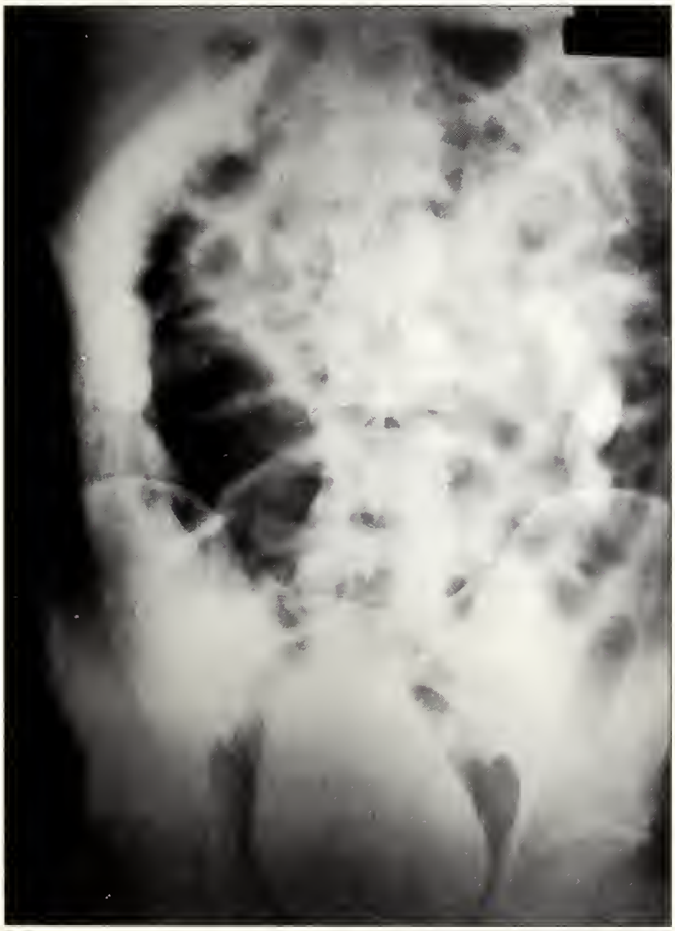


Figure 1

A 27-year-old man was brought to the emergency room following a car accident. Urianlysis showed grossly bloody urine. Your are shown an A.P. film from a cystogram (Fig 1).

What is the diagnosis?

a. Ruptured spleen

b. Kidney laceration

c. Intraperitoneal bladder rupture

d. Extraperitoneal bladder rupture

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

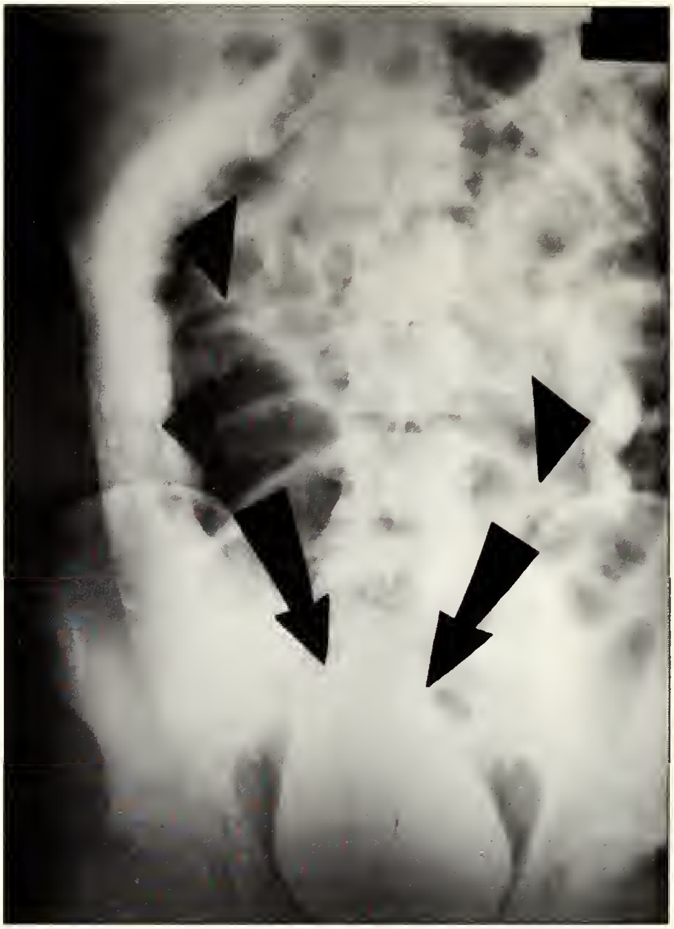
ANSWER: c. Intraperitoneal Bladder Rupture

The cystogram shows good filling of the bladder, with an unusual protrusion at the superior bladder contour (large arrows). There is also a large contrast collection extending superiorly into the right paracolic gutter and subhepatic space, and a small contrast collection between bowel loops in the left mid abdomen (arrowheads). The above findings indicate bladder rupture with leakage of contrast medium into the peritoneal space. At laparotomy, a large tear was found at the dome of the bladder (option C is the correct response).

Bladder rupture is most commonly seen in blunt or penetrating trauma to the pelvis. Associated pelvic fractures are common, with 80% of bladder ruptures seen with pelvic fractures being the extraperitoneal type. Clinically, patients usually present with gross hematuria, abdominal pain and inability to void.

In patients with hematuria after trauma, a retrograde urethrogram should be performed initially to rule out urethral injury. If this is negative, a retrograde cystogram is performed to look for extravasation or deformity of the bladder by pelvic hematoma. It is important to adequately distend the bladder to look for a tear. Intraperitoneal ruptures (as in this case) show leakage of contrast into the peritoneal space. Extraperitoneal ruptures show irregular contrast leakage into soft tissue planes around the bladder base. Some studies indicate that C.T. scanning can visualize bladder ruptures which are not well seen on plain cystography.

Option A, ruptured spleen, is incorrect since there is no soft tissue mass visible in the left upper quadrant to indicate splenic or perisplenic hematoma.



Repeat Figure 1

Option B, kidney laceration, cannot be determined without contrast visualization of the kidney. However, clinical findings are explained by the bladder rupture in this case.

Option D, extraperitoneal bladder rupture, is incorrect since the contrast leakage is into the peritoneal space rather than the extraperitoneal space.

References

1. Hortman WG, McClennan BL and Heiken JP. Comparison of Computed Tomography and Conventional Cystography for Detection of Traumatic Bladder Rupture. *Urol Radiol* 1991;12:188.
2. McCort JJ, Ed. *Trauma Radiology*, 1990, Churchill Livingstone, p. 276.

Membership Notes

Larry K. Chase, MD, of Springfield, was recently inducted as a Fellow of the American College of Endocrinology (ACE), the educational and research arm of The American Association of Clinical Endocrinologists (AACE). To be accepted, Dr. Chase had to be a member in good standing of the AACE and meet the qualifications of one of five routes to fellowship.

Frederick W. Hahn, Jr., MD, immediate past president of the MSMA, was named an honorary alumnus of the University of Missouri-Columbia School of Medicine. Dr. Hahn, an ear, nose and throat specialist practicing in Independence, received his medical degree from the University of Iowa. He is a staff physician at St. Mary's Hospital of Blue Springs and at Independence Regional Health Center, where he also served as staff president. He is past vice president and board member for the Medical Center of Independence and past president of the Metropolitan Medical Society of Kansas City.

Edward R. Jenkins, MD, was elected President of the Mid-Missouri Medical Society (MMMS) during its recent membership meeting. Dr. Jenkins is a family practitioner with an office in Waynesville. He will serve a one-year term as the organization's leader. Dr. Jenkins succeeds **Barry Bass, MD,** who served as President for several years. **Katherine Cook, MD,** a pediatrician from Rolla, was elected MMMS Secretary-Treasurer.

Beginning next spring, University of Missouri-Kansas City medical students will have the opportunity to work with former dean of UMKC School of Medicine, **James J. Mongan, MD,** at his new position at Massachusetts General Hospital. The fellowship has been set up as a one-month credit elective taken by a fifth- or sixth-year UMKC medical student. Dr. Mongan will supervise the curriculum, which can include topics such as health policy, medical economics and executive leadership. It is funded through support from the TMC Charitable Foundation, Truman Medical Center, the Hospital Hill Health Services Corporation, the UMKC School of Medicine and Diastole-Hospital Hill Inc.

Will R. Ross, MD, has been named associate dean and director of the Office of Diversity at Washington University School of Medicine. Dr. Ross was the vice president for medical affairs at St. Louis Regional Medical Center. Dr. Ross will lead minority medical student admissions and minority student affairs as well as focus on broader issues of diversity. In addition, he will hold the position of assistant professor of medicine, with an appointment in the renal division, where he will continue to see patients and teach.

Sixty former Washington University neurosurgery residents expressed their esteem for a couple who always took a personal interest in residents by endowing the **Henry G. and Edith R. Schwartz** Chair in Neurological Surgery at the medical school. The Schwartzs moved to St. Louis in 1936, when Dr. Schwartz became a fellow in neurological surgery at Washington University. During that year, he made the first direct recording in the U.S. of electrical activity from the human brain. In 1937, he joined the school's faculty as an instructor, performing one of the earliest randomized studies in neurosurgery, on the effect of lumbar puncture in reducing the pressure inside the skull in severe head injuries. He received the prestigious Legion of Merit in 1945 for developing a standard procedure for handling wounds of the head and nerves during World War II. He was head of neurological surgery from 1946 to 1974, and became the August A. Busch Jr. Professor in 1970, taking emeritus status in 1984. During this period, he was instrumental in establishing the medical center's craniofacial reconstruction program. In 1983, Dr. Schwartz's colleagues and former residents established the annual Henry G. Schwartz lectureship. He held many academic and professional appointments and is the recipient of many honors. Dr. Schwartz continues to be active in the daily life of his department. His wife, "Reedie," whose professional name was **Edith Courtenay Robinson, MD,** served in the County Health Department's clinics during World War II. She later became assistant clinical professor of pediatrics at the medical school and joined the staff of St. Louis Children's Hospital. With a subspecialty in pediatric psychiatry, she worked in the university's Child Guidance Clinic and was the consulting physician for the Ladue School District and Mary Institute. She died in December 1994.

Saint Luke's Hospital Foundation and UMKC secured its first endowed chair. The **Gerald F. Tuohy, MD,** Endowed Chair in Research becomes the first endowed chair at Saint Luke's Hospital of Kansas City. It is funded by contributions from Dr. and Mrs. Gerald F. Tuohy and Westport Anesthesia Services, Inc.

Physicians' Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

Luis A. Acosta, ***Rolla***
Charles W. Barbee, ***Columbia***
Rogelio L. Bautista, ***Moberly***
Robert E. Bolinske, ***St. Louis***
Barbara N. Buchanan, ***Kansas City***
David A. Caplin, ***St. Louis***
John B. Crane, ***Washington***
Horacio T. Crespo, ***Warrenton***
Remedios R. Crespo, ***Warrenton***
John A. Crouch, ***Columbia***
Robert K. Dorton, ***St. Louis***
Thomas M. Farrell, ***St. Louis***
Dominic S. Francisco, ***St. Louis***
Joseph Gagliardo, ***Clayton***
Richard J. Gimpelson, ***Chesterfield***
Mario J. Guastello, ***Kansas City***
Vincent P. Gurucharri, ***Columbia***
Joel D. Hassien, ***Hannibal***
Mark J. Hoffman, ***St. Louis***
Pamela J. Honeycutt, ***Columbia***
James A. Junker, ***St. Louis***
Jerry L. Kinder, ***Cape Girardeau***
Edward D. Kinsella, ***Richmond Heights***
Allen P. Klippel, ***Clayton***
Roy N. Kohler, ***Springfield***
John P. Koonce, ***Jefferson City***
Russell R. Kraeger, ***St. Louis***
Norton S. Kronemer, ***St. Louis***
Carleton J. Lindgren, ***Independence***
Mark H. Loeb, ***Columbia***
William B. Mangum, ***Independence***
Carol R. Mischnick, ***St. Louis***
Carl M. Myers, ***Platte City***
Mauro A. Paez, ***St. Louis***
David E. Perkins, ***Chesterfield***
Kenneth R. Powell, ***Springfield***
Philip D. Reister, ***Kansas City***
Frank G. Rieger, ***Columbia***
David T. Rispler, ***Jefferson City***
Alan J. Scharrer, ***Lee's Summit***
Mark A. Scheperle, ***Clayton***
Paul G. Schneider, ***St. Louis***
Stuart A. Seale, ***Springfield***
Michael B. Sheehan, ***Kansas City***
Stephen G. Slocum, ***St. Louis***
Robert M. Thomas, ***Columbia***
Joseph W. West, ***Kirkwood***
Vallee L. Willman, ***St. Louis***
Warren T. Wilson, ***Springfield***

In Memoriam

Clyde Max Witt, MD, 80, Washington, Missouri, died May 17, 1996. Dr. Witt received his medical degree at Washington University in 1943. He served in the Army during World War II, and began practicing radiology in 1949. He was a founder of Radiological Associates which provided radiological services for more than 30 years to Missouri Baptist Medical Center, Incarnate Word Hospital and Bethesda General Hospital. He was also on the staff at St. Louis University's School of Medicine for 25 years. Dr. Witt retired in 1981. He was active in the St. Louis Metropolitan Medical Society, the Missouri State Medical Association, and the Greater St. Louis Society of Radiologists. Dr. Witt was elected a fellow in the American College of Radiology in 1965. He was also a member of the Radiological Society of North America.

Harry K. Cohen, MD, 85, Overland Park, Kansas, died May 15, 1996. Dr. Cohen received his medical degree at the University of Kansas in 1935. He was a family physician for 54 years, and was the Medical Director at Shalom Geriatric Center for 22 years. He was honored with its Hy Vile Community Service Award in 1988. Dr. Cohen was on the staff at Menorah Medical Center, St. Mary's Hospital and Baptist Medical Center. He was born in Russia and came to Kansas City from there in 1911. Dr. Cohen was a member of the American Academy of Family Physicians.

Richard A. Twyman, MD, 83, Independence, Missouri, died April 15, 1996, Dr. Twyman received his medical degree at Northwestern University, Chicago, Illinois, in 1938. He served as a major in the Army medical corps during World War II. Dr. Twyman was a professor of surgery at the University of Missouri. He retired in 1988. Dr. Twyman was the fifth and final generation of Twyman doctors to practice in Jackson County. He was a member of The Southwestern Surgical Congress and the American College of Surgeons.

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine****, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

Informed Consent: An Evolution From Battery/Medical Negligence to Potential Invasion of Physician Privacy

Dora Reid, BSN, JD/MBA

From no consent at all, or battery, to a claim for medical negligence to today's possible new requirement for personal information about the treating physician, the Doctrine of Informed Consent has always raised the question: *what do I actually tell this patient to effectuate informed consent?* "Informing" the patient was far easier when failure to inform constituted battery. Since the consent to the treatment of a specific body part negated battery, the health care provider simply told the patient what treatment would occur or what part of the body would undergo surgery. Then, if the surgeon operated on the specific body part and the physician carried out the specific treatment which he or she had described to the patient, the patient was considered "informed."

As different parts of the country began to treat consent as part of a formal doctrine, and began treating the absence of consent in health provision as medical malpractice, a number of legal components requiring legal definitions began to dictate what a physician must tell his or her patient before performing a treatment to comply with the law. Failure to obtain the patient's informed consent not only resulted in the patient's lost opportunity to refuse, but also exposed the health care provider to a lawsuit where a jury received specific instructions regarding: (1) what constituted a valid claim of failure to obtain informed consent; (2) what specific standard determined if the consent was informed or not; (3) what the patient had to show to prove that the physician failed to obtain informed consent.

Missouri courts first recognized the Doctrine of Informed Consent as a medical malpractice action in 1959. *Steele v. Wood*, 327 S.W. 2d 187, 198-99 (Mo. 1959). Although the courts had long required expert testimony from members of the physicians' profession regarding skills and techniques exercised in other medical negligence actions, they had not required expert testimony to establish whether or not a doctor had complied with his or her duty to communicate the nature and risks of the intended treatment. If the patient testified that the physician did not discuss the risks of the procedure in advance, the court submitted the case to the jury, which then considered the "bad result" without benefit of expert guidance.

Not until 1965 did Missouri law require an expert to inform the jury what risks should be discussed with the patient and at the same time established the standard of what constituted informed consent based on what a reasonable medical practitioner would do. *Aiken v. Clary*, 396 S.W. 2d 668 (Mo. 1965), "Such a practitioner would consider the state of the patient's health, the condition of his or her heart and nervous system, his or her mental state and would take into account, among other things, whether the risks involved were mere remote possibilities or something which occurred with some sort of frequency or regularity." *Aiken* held that this determination involved medical judgement as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed.

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A valid claim of failure to obtain informed consent, comprises three elements: **duty, proximate cause,** and **injury**. To prevail on a medical malpractice claim based upon lack of informed consent, the plaintiff patient must show:

1. The physician had a duty to disclose **material** information regarding proposed treatment;
2. The physician failed to disclose **material** factors;
3. The failure to disclose caused the injury underlying the claim.

The plaintiff could no longer obtain damages by simply showing that the health care provider failed to disclose material factors. He or she also had to prove that an injury occurred and that the failure to disclose caused the injury.

The test for **materiality** is an objective one; a patient has a right to know those hazards that a "reasonable prudent person" would find significant in deciding whether to undergo treatment. Under that description, informed consent generally includes a discussion of the following:

1. Benefits v. The Risk of Treatment;
2. The suggested treatment;
3. Alternatives available;
4. Risks associated with those alternatives;
5. Possible consequences of no treatment.

Then, and only then, can a physician know that he or she has supported the conviction of the long ago famous jurist, Judge Cardozo, who once stated, "Every human being of adult years and sound mind has a right to determine what should be done with his own body." Only if that person is fully informed with sufficient information, can he or she make an intelligent decision.

Certain patients are unable to consent because of their unconscious state, age or mental limitations. This article does not purport to include those patients whose specific inabilities to consent have resulted in special federal regulations, federal statutes, development of advanced care directives and durable power of attorney, and various institutional protocols and guidelines to preserve those patients' specific rights.

Certain considerations in determining exactly what to say to the patient, involve the following:

1. *Patient autonomy v. patient benefit* - does the health care provider tell the patient everything he or she can determine relative to the treatment or surgery? Or, does the physician look at the patient as an individual, decide what the patient actually needs to know and then obtain consent in a way that is comprehensible and consistent with the person's language, custom, and culture. How should physicians dedicated to the best interest of their patients, conduct therapeutic relationships with patients whose cultural values differ markedly from their own.

2. *Do no harm* - the exception to the duty to disclose risk information recognizes that under some circumstances disclosure of certain risks would not be in the patient's best interest. The duty to disclose then becomes the therapeutic privilege of withholding truth if the physician foresees a significant probability of causing emotional damage. For example, an anesthesiologist preparing a patient for surgery must determine when the recitation of so many details about what may happen during the surgery poses a risk of great physiological risk and preoperative agitation which outweigh the need to disclose all the details.

3. *Maximize possible benefits* - a patient/plaintiff's initiation of a lawsuit against a health care provider for failure to obtain informed consent overlooks the therapeutic doctor/patient relationship out of which the issue(s) arose. Such a relationship attempts to eliminate exhaustive lists of information that confuse patients, adversely affect the physician/patient relationship, and create barriers to communication and truth. What is best for the patient because of the litigation fear, becomes secondary in such a cautious environment, leading to:

(1) the practice of defensive medicine;

(2) decrease in trust between a physician and patient;

(3) legal formalism including fixed disclosure requirements, boiler plate written consent forms, and checklists of information which the patient cannot fully understand;

(4) patient confusion with details that he or she does not want, nor needs to hear; and

(5) needless patient alarm regarding very remote risks. Sometimes the patient refuses to hear certain details. Courts have usually supported the physician when the patient exercises his or her right to receive limited or no information at all.

Still the individual health care provider must determine the exact content as well as the language he or she uses to inform the patient. Since Missouri law determines if the health care provider has obtained informed consent based on what his or her colleagues tell a patient under the same or similar circumstances, the health care provider can usually maintain a valid defense regarding his or her statements to patients if he or she remains aware of what constitutes "informed consent" among the health care providers in his or her field by obtaining their input regarding patient needs and the statements that most benefitted their patients in preparation for certain procedures. Doctors, legal experts, and patient representatives need to discuss what should and should not be told to patients in particular situations, not only to avoid lawsuits or at least to obtain a favorable verdict in the event of a lawsuit, but also to improve communication and understanding and enhance the therapeutic effect of the patient/physician relationship.

We have discussed the elements of informed consent, the definition of certain key phrases within the doctrine such as "materiality," and the applicability of Missouri law. Before 1991, the discussion of informed consent would have concluded at this point. However, in the August, 1994 issue of the *ENT Journal*, Dr. Donald A. Shumrick explored what he termed "the widened scope of informed consent" based on two landmark decisions. *Hidding v. Williams* and *Beherenger v. The Medical Center at Princeton, New Jersey*. According to Dr. Shumrick, these cases demonstrated the possibility that informed consent might one day include, not only the information about the intended treatment, but also personal data about the physician that might impact the treatment of the patient.

In *Hidding* the plaintiff received a judgment in his favor because he was not informed that alcohol abuse from which his surgeon was suffering at the time of the treatment increased potential injury during surgery. The court ruled that a **material** risk had not been disclosed and therefore, the patient could not have decided upon the surgery based on fully informed consent.

Beherenger involved a physician with AIDS. Although the court supported the surgeon based on the New Jersey law against discrimination, the hospital required the doctor to inform his patients that he had AIDS so that they could decide whether they should choose another surgeon.

Dr. Shumrick began his article by posing these questions intended for the treating health care provider: Are you being treated for drug or alcohol abuse? How many malpractice cases have been brought against you? Are you dealing with any personal issues that are causing you emotional distress?

Dr. Shumrick then suggests that one day such questions may become part of the Doctrine of Informed Consent.

To conclude, while the primary purpose of this article was to explore the evolution of informed consent and provide the legal components of the doctrine, a second and equally important purpose was to encourage health care providers to find creative ways to facilitate informed choices which are therapeutically and specifically designed to enhance their physician-patient relationships.

The Author

Dora Reid, BSN, JD/MBA, is a graduate of the University of Kansas School of Law and Graduate School of Business, and Boston University School of Nursing. She is a member of a law firm, Blackwell Sanders Matheny Weary & Lombardi L.C., in Kansas City, Missouri. Her professional affiliations include the American Bar Association Litigation Committee; Missouri Bar Association Health & Hospital Law Committee; Kansas City Metropolitan Bar Association; Jackson County Bar Association; Association of Women Lawyers; and Missouri Nurses Association. She is also active with the Kansas City Free Health Clinic; Community Home Health Care, Inc.; Jackson County, Missouri Chapter of LINKS, Inc.; and, YouthNet.

Arbitrage Opportunity: Medicare HMOs are on the Rise

Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

The federal government clearly sees Medicare beneficiaries continuing to move into managed care. The Health Care Financing Administration (HCFA) is paying Medicare "Risk" HMOs 95% of the average cost of a Medicare beneficiary for that specific county. Beneficiaries seem pleased with the HMO benefits because most provide more generous benefits for less out of pocket expense.

For physicians, Medicare Risk HMOs present an opportunity, see chart below for Missouri results. The AAPCC (average adjusted per capita cost) paid by HCFA to HMOs easily covers the medical cost for well managed seniors leaving an opportunity for profit, see chart on next page for selected counties in Missouri. Physicians who have organized into managed care contracting groups have the ability to enter into risk sharing arrangements with Medicare Risk HMOs. Additionally, this type of arrangement allows physicians to preserve the patient-physician relationship which may be threatened in the future as patients migrate to these HMOs. **MoMed**

Medicare Risk Contracts by HMOs doing business in Missouri, 1995

CASH BASIS OPERATING RESULTS

HMO	Paid for Health Care Services	Premiums Collected	Medical Expense Ratio	Member Months	Per Member Per Month Profit (PMPM)
BlueChoice	$5,741,627	$9,297,674	62%	21,703	$164
GenCare Health Systems, Inc.	3,653,428	4,819,454	76%	13,640	85
Good Health HMO, Inc.	3,205,657	5,408,604	59%	10,902	202
Group Health Plan, Inc. (GHP)	14,082	32,712	43%	270	69
Humana Kansas City, Inc.	22,890,658	33,292,322	69%	79,254	131
Physicians Health Plan of Greater St. Louis, Inc. (PHP)	17,902,022	22,182,964	81%	55,014	78

ACCRUAL BASIS OPERATING RESULTS

HMO	Paid and Accrued Health Care Services	Premiums Earned	Medical Expense Ratio	Member Months	Per Member Per Month Profit (PMPM)
BlueChoice	$6,820,162	$7,705,903	89%	21,703	$41
GenCare Health Systems, Inc.	3,712,347	4,046,821	92%	13,640	25
Good Health HMO, Inc.	3,966,836	4,822,070	82%	10,902	78
Group Health Plan, Inc. (GHP)	11,894	32,780	36%	270	77
Humana Kansas City, Inc.	30,183,334	33,282,580	91%	79,254	39
Physicians Health Plan of Greater St. Louis, Inc. (PHP)	18,823,495	19,100,757	99%	55,014	5

Source: Missouri Department of Insurance

"Top 50" Missouri Medicare 1996 Average Adjusted Per Capita Cost for Risk HMOs

	County	AGED Part A	Part B	Total
1	St. Louis City	$348	$154	$502
2	Jackson	301	171	472
3	Ray	294	169	463
4	Lincoln	301	156	457
5	Jefferson	305	150	455
6	Clay	283	168	452
7	Warren	301	148	450
8	Maries	308	138	446
9	St. Louis	286	153	439
10	Platte	277	160	437
11	Camden	282	145	427
12	St. Charles	274	151	425
13	Audrain	288	133	421
14	Lafayette	265	152	416
15	Boone	276	138	413
16	Aadair	275	138	413
17	Clark	282	122	404
18	Cole	268	137	404
19	Cass	250	154	403
20	Ralls	289	115	403
21	Taney	273	126	399
22	Hickory	265	133	398
23	Randolph	261	128	389
24	Reynolds	266	124	389
25	Sullivan	254	133	388
26	Callaway	256	130	385
27	Dent	263	122	384
28	Marion	281	104	384
29	Miller	256	128	384
30	Howard	260	124	384
31	Johnson	242	141	383
32	Pike	252	130	382
33	Osage	255	128	382
34	St. Francois	254	127	381
35	Montgomery	254	123	377
36	Polk	263	113	376
37	Knox	246	128	375
38	Crawford	248	124	372
39	Barton	255	117	372
40	Pettis	245	126	371
41	Schuyler	249	121	370
42	Dallas	252	117	370
43	Saline	250	119	369
44	Morgan	243	125	369
45	Phelps	259	109	368
46	Butler	248	119	367
47	Franklin	241	125	366
48	Washington	238	128	366
49	Pulaski	256	109	365
50	Buchanan	225	138	363

"Top 50" Uedicare 1996 Average Adjusted Per Capita Cost for Risk HMOs

	State	County	AGED Part A	Part B	Total
1	NY	Richmond	$538	$221	$759
2	NY	Bronx	529	204	734
3	NY	New York	490	225	715
4	NY	Kings	486	217	703
5	LA	Sternard	459	233	692
6	LA	Plaquemines	462	225	688
7	FL	Dade	335	352	687
8	PA	Philadelphia	459	222	681
9	FL	Okeechobee	445	229	674
10	NY	Queens	455	197	652
11	MI	Wayne	382	245	628
12	MD	Baltimore CI	419	195	614
13	FL	Broward	327	283	610
14	CO	Cheyenne	448	158	605
15	LA	Cameron	429	175	603
16	LA	Jefferson	397	206	603
17	MA	Suffolk	412	187	600
18	AL	Shelby	410	189	599
19	MI	Oakland	351	246	597
20	LA	Stharles	410	185	596
21	LA	Ascension	408	187	594
22	CA	Los Angeles	360	228	587
23	LA	St Tammany	402	185	587
24	MI	Genesee	360	227	587
25	MD	Prince George	369	217	586
26	NY	Rockland	385	200	585
27	MI	Macomb	333	245	578
28	DC	Washington D	374	202	576
29	NY	Nassau	376	199	575
30	LA	Orleans	394	179	573
31	LA	Stohn Bapt	416	157	572
32	NV	Esmeralda	398	170	568
33	GA	Clayton	367	197	564
34	NY	Putnam	368	196	563
35	LA	Livingston	382	180	562
36	LA	Washington	371	191	562
37	PA	Allegheny	371	187	559
38	GA	Clinch	375	183	558
39	MA	Norfolk	368	190	558
40	FL	Monroe	354	204	558
41	NY	Westchester	364	188	552
42	MA	Dukes	392	160	552
43	CO	Lake	390	160	550
44	MD	Anne Arundel	357	191	549
45	GA	Douglas	366	182	548
46	PA	Delaware	346	201	547
47	MS	Jackson	387	159	546
48	MD	Howard	353	192	545
49	CA	Orange	327	217	545
50	MS	Hancock	358	184	542

St. Louis City, Missouri is #108 in the U.S.

Missouri HMOs, 1993-95, Medical & Administrative Expense Percentages

Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

	1993		1994		1995	
Missouri HMO	**Medical Expense shown as % of Revenue**	**Admin Expense shown as % of Revenue**	**Medical Expense shown as % of Revenue**	**Admin Expense shown as % of Revenue**	**Medical Expense shown as % of Revenue**	**Admin Expense shown as % of Revenue**
Alliance for Community Health					82%	33%
BMA Selectcare, Inc.	81%	20%	77%	20%	85%	24%
CIGNA Healthplan of KS / MO	84%	15%	72%	28%	75%	26%
Community Health Plan					104%	51%
Exclusive Healthcare (KC)	89%	13%	96%	14%	97%	19%
Gencare Health Systems	78%	11%	77%	10%	78%	15%
Good Health (BlueCare)	71%	9%	66%	9%	79%	6%
Group Health	89%	11%	87%	12%	88%	12%
HealthCare USA					84%	16%
HealthLink	84%	146%	83%	32%	83%	14%
HealthNet			82%	54%	82%	34%
HMO Missouri (BlueChoice)	67%	17%	70%	16%	75%	26%
Humana Health Plan	82%	13%	82%	13%	83%	12%
Humana Kansas City	83%	14%	84%	13%	85%	13%
Kaiser of KC	80%	16%	79%	19%	79%	18%
Medical Center Health Plan (Partners)	86%	13%	86%	12%	83%	14%
Mercy Health Plans of MO					90%	107%
MetraHealth of KC			85%	16%	77%	15%
MetraHealth of St. Louis			75%	16%	69%	13%
PHP of Greater St. Louis	80%	16%	81%	17%	83%	17%
Principal Health Care of KC	76%	16%	76%	21%	85%	22%
Prudential (Prucare of KC)	79%	13%	83%	15%	85%	16%
Total Health Care (now BCBSKC)	83%	7%	71%	10%		
TriSource (BlueAdvantage)			88%	11%	93%	10%
Truman Medical Center	69%	14%	72%	15%	76%	16%

Note: Not shown is the net income as a percent of revenue.

Source: Missouri Department of Insurance

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Committee to Study a Statewide Managed Care Organization

Patrick J. Mills, MBA, CPA, MSMA Director of Health Care Finance

A committee was created to respond to the MSMA 1996 House of Delegates Resolution #5 which states:

Resolved, that the Missouri State Medical Association, in cooperation with Missouri State Medical Services, Inc., Renaissance HealthCare Partners, Inc., and other sources, develop a report on the feasibility of organizing a physician owned and operated managed care organization and that this report be provided to the MSMA membership after being presented at the August 1996 MSMA Council meeting.

On May 31 and June 1 the Committee to Study a Statewide Managed Care Organization met at Lake Ozark Holiday Inn.

To ensure the committee had a fundamental understanding of the MSMA, President Dan O'Sullivan, MD, began the meeting with a reading of the Association's mission statement:

"The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri."

The committee was given a detailed report of the actions initiated by the MSMA through the creation of its Physician Directed Organization Committee (PDO) and its successor the Missouri State Medical Services, Inc. (MSMS). While the PDO Committee studied what the MSMA response should be to the rising tide of managed care, MSMS has been active in initiating physician organizations. Over the past two years, Tom Bennett, MSMS Executive Vice President, has spoken to many medical societies and provided services to IPAs (independent practice associations) and multi-specialty groups in all parts of Missouri. Most recently he has been the acting Executive Director of Renaissance HealthCare Partners in Kansas City.

The committee discussed the MSMA's range of options from doing nothing to initiating physician capitalization of a full risk HMO.

Dr. O'Sullivan reported that the primary area of action for state medical associations is to develop management services organizations. He was the only physician in attendance during the AMA COSMO (Clearinghouse On Society Sponsored Managed Care Organizations) meeting held in Chicago on May 17. The meeting was also attended by medical association staff from Massachusetts, New York, Pennsylvania, Michigan, Ohio, Indiana, Illinois, and the District of Columbia.

Four speakers gave presentations to the committee to help develop the specifics of pursuing the development of a managed care organization. Michael Wood addressed, "Physician Leadership"; Michael Collison, MD - "Development of a Managed Care Product"; Gordon Hanebutt - "Marketing a Managed Care Product"; and, Tom Bennett - "Management Services Organization."

When the committee reconvened on Saturday, the discussion focused on what MSMA should do to respond to the needs of its members. The committee reached a consensus that what is most needed is assistance for physicians organizing to contract with managed care. The establishment of an HMO was discussed, but it was widely agreed that physicians would not be able to adequately capitalize an HMO to survive price competition or even nuisance lawsuits. The only realistic HMO alternative would be to joint venture with an existing HMO which would provide access to capital, underwriting talent, marketing, and information systems.

Because physician organizations are a more primary building block in the assumption of risk under managed care, the committee recommended to the MSMA Council that the MSMA form an Management Services Organization (MSO) sponsored or owned by the MSMA.

As a result of the committee's two-day, 175-hour study, the following recommendations were approved by the MSMA Council on June 2:

1. That the MSMA Council endorses the concept of a statewide MSO as proposed by this Committee and MSMS.

2. That the MSMA Council authorizes the Board of Directors of MSMS, in consultation with the MSMA Executive Committee, to proceed with the formation of an MSO as proposed by the Saint Louis Management Group (SLMG).

MSMS has been involved in negotiating for the formation of an MSO with SLMG since last October. The MSMA Council recommended on April 24 that MSMS proceed with the MSO proposal subject to the approval of the MSMA Executive Committee.

Members of the Committee to Study a Statewide Managed Care Organization

Daniel O'Sullivan, MD	MSMA President *
A.J. Campbell, MD	MSMA President-Elect
David Wilkinson, MD	MSMA First Vice President
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* denotes MSMS board of directors membership

The MSMS board of directors met by conference call on June 5 and voted to proceed with the MSO proposal received from SLMG. Over the next few weeks MSMS will be working with SLMG to develop contract language for the establishment of the MSO under a joint venture arrangement.

While the resolution called for a feasibility study of organizing a physician owned and operated managed care organization, the committee recommended to the MSMA Council what it believes to be a more primary ingredient to address the needs of Missouri physicians - the development of a management services organization (MSO). By providing access to top management talent through the proposed MSO, physicians will be better organized to compete for managed care contracts.

A Physician's View of Managed Care Contracting

Timothy McIntire, MD, MBA

The first thing any physician should do when evaluating a contract of any kind, managed care or not, is to involve a knowledgeable attorney. That being said, there are many things physicians and their managers can do to protect themselves from a bad managed care contract prior to obtaining legal advise.

Framework For Negotiation

Negotiations with managed care companies often introduce or redefine relationships between the company and physicians. It is important to be organized, articulate and focused on your needs and wants when you prepare for the first and subsequent meetings with the managed care company. Developing a good relationship with the managed care company and adopting a "managed care friendly," proactive attitude is often helpful in successfully negotiating a good contract.

Team negotiations are stronger than single person negotiations. A team of two to four people representing different areas of expertise within the practice (operations, finance, physician, etc.) is useful in this negotiation process. The team should predetermine one person who will be the spokesperson. The team should then discuss and prioritize their goals. Prior to the initial meeting, it is helpful to research the managed care company. Information regarding the company's ownership, financial strength, management and physician reimbursement options (fees, capitation, budgets, with-holds, etc.) is useful in prioritizing your own goals. Demographic data concerning what other physicians will be in the network, what hospitals will be in the network, physician utilization incentives and restrictions, the type of physician/employer to be targeted and the benefit design (in network - out of network copayments, etc.) should be determined.

It is important to **write down** your goals and determine which ones are negotiable and which ones are not. Which points can you sacrifice for a better fee schedule, exclusivity, steerage, etc.? Organization and preparation are the key to a successful experience.

Steps In Contract Negotiation

- **Develop a Negotiation Team, Pick One Spokesperson**
- **Do the Background Research and Get a Sample Contract**
- **Establish Your Contracting Goals**
- **Evaluate the Contract**
- **Selection of the Correct Contract**
- **Administration of the Contract**
- **Renegotiation of the Contract**

Establishing Your Contracting Goals

There should always be a business reason to enter into any managed care contract. The most obvious reason is usually to maintain access to your patients. Secondary goals to be considered often include growing your patient base, changing your patient mix, improving your cash flow, and building relationships (business and personal) in the community. The strategy you use in contracting may vary depending on your goals for contracting. If you are attempting to grow your patient base, then a managed care company with name recognition and a good marketing plan/ benefit design to target your patient base may be very important. If you are attempting to improve your cash flow, you may consider discounting your fees for increases in volume, especially if this increase in volume dilutes some of your fixed overhead costs, thus improving your practice's profits. Different practice goals...different contracting goals.

Evaluating the Contract

Does the contract bring your practice new patient care opportunities, or do you need the contract to protect the practice from erosion? Does the contract offer you a share in any profits generated from physician efficiencies? Does the contract offer you access to a specialty network or hospital which may better serve your patients? How is your with-hold calculated, and what is the history of returning with-holds by the company? These are often patient care issues with an economic flavor which may need some form of financial analysis to evaluate. Unless physicians understand how managed care companies function, they will not be able to understand what concessions to ask for when approached with a contract requesting discounted fees. A careful review of your practice and contracting goals during the evaluation phase often helps focus attention on the physician's needs.

Selecting the Correct Contract

Not every contract will be good for a physician's practice. Participation in contracts may be of an "offensive" nature, such as growing the practice, or of a "defensive" nature, such as protecting a declining patient base. Regardless of the strategy, a bad contract can do more harm than no contract at all. Selection criteria should include an assessment of: potential new member enrollment, strong/stable management, the make-up of the provider network, the amount of utilization risk management assumed (or not assumed) by the practice and the revenue this group of patients will contribute to the practice. Technical aspects such as coordination of benefits, payment terms, and the paperwork associated with managed care patient encounters may seem like minute issues, but they can cause significant disruption to a clinic if they are not properly addressed.

Administration and Preparation For Renegotiation

It is important to measure the implementation of successes or failures that a managed care contract brings to the clinic. These contracting relationships are often renewed over time. Making sure the managed care company acted in good faith and lived up to their contractual obligations as they relate to your original goals is not only important, but it should be revisited over time. There are always aspects of each deal which are realized during the implementation and service of any contract which should be addressed during the renegotiation period. Articulating these points in a coherent, non-emotional way leads to success in the renegotiation phase.

In conclusion, researching the new (potential) partner is always helpful as contract negotiations begin. Obtaining a sample contract and getting information from the state Department of Insurance serve as the beginnings of the background research. Involving a good health care attorney during this process will help ensure your success in this contracting adventure.

The Author

Timothy McIntire, MD, MBA, is a partner with Boyce and Bynum Pathology Labs, of Columbia, Missouri and is a Managed Care Consultant for Jefferson City Medical Group.

Using Relative Value Units (RVUs) to Develop Your Pricing Schedule

Gary M. White, CPA, MBA and Tom Bennett, MDiv, MSW, MBA, GCG

This article presents a methodology by which a practice, using published Medicare Relative Value Units, can develop a logical and consistent pricing structure which recognizes the difference between procedures and is of a similar methodology to that used by Medicare and many major third-party payors in reimbursing practices. This approach utilizes available published information and can be done with relative ease by all physician practices.

Using Relative Value Units to Develop Your Pricing Schedule

One of the most important decisions that a business has to make is to determine its pricing strategy for its products/services in order for this business to remain competitive and to remain profitable. The standard method used by business to establish a price for a product/service is to determine the actual cost for producing a product/service and then adding a margin of profit to the cost.

The purpose of this article is to establish a scientific methodology to determine a pricing strategy for physician fees. This methodology should be based on accepted business principles and standards of practice. The most common and accepted method that is being utilized in designing a physician fee schedule is one based on a relative value system as used by the Health Care Finance Administration (HCFA) for Medicare part B. Based on the work of William Hsiao and his Harvard team, HCFA, in 1992, instituted Resource Based Relative Value Scale (RBRVS) to stabilize the cost in the Medicare program and to create equity in payments to physicians by setting standard rates for services regardless of the specialty.

The majority of commercial payors are now moving to a relative value system of reimbursement; therefore, it is contingent on practice administrators to begin to design their fee schedules according to this method.

Some people question the actual need to spend the time and resources in designing a fee schedule, because of the predetermined payments from managed care organizations and fixed payments from Medicare. However, the following should be noted:

(a) PPO pricing is generally negotiated according to the fee schedule.

(b) There is still a percentage of indemnity insurance.

(c) Certain specialties have high percentage of cash paying patients.

(d) The methodology described below gives the practice a baseline to judge the impact of risk contracts and assists in the evaluation process.

There are two basic components in any relative value system; i.e., the relative value scale and the appropriate conversion factor.

The Relative Value Scale is used to assign a "weight" to each CPT code and thereby establishes a form or relativity between all services. Some services are obviously more complex than others; hence, they have higher relative values within the scale. These "weights" are measured in relative value units and are referred to as Relative Value Units (RVUs).

In the April 1996 issue of *Missouri Medicine*, the article "Analyzing Practice Costs Utilizing Relative Value Units" outlines a similar spreadsheet methodology which allows a practice to determine its cost per RVU by converting its monthly production report to Relative Value Units and dividing the RVUs into the practice's cost for the same period. The resultant cost per RVU multiplied by the RVU for each CPT code provides an estimate of the practice's cost per procedure which serves as a baseline in developing the procedural fee.

The Conversion Factor is a simple multiplier which is used in conjunction with the RVU to determine a standard fee for a service.

A fee schedule should not be established in isolation but within the whole context of reimbursement management. Reimbursement management is a system that is designed to maximize the revenue of the practice and, as in any system, the output is only as good as the components in the system. The key components of this system include:

- Data Collection: the **Accurate** and **Timely** collection of patient's demographic, social, financial, and insurance information at the first point of contact.
- Accurate and timely coding and verification procedures.
- Charge entry/billing.
- Generation of reports for accounts receivable management.
- Cash posting.
- EOB analysis.
- Medical record auditing to verify documented authenticity of claim.
- Third-party comparative payment analysis.

The Methodology

There are four major components in calculating a fee schedule and these include:

1. The current market data on allowables by CPT code.
2. Identification of the major CPT codes which generate the majority of the practice charges/cash.
3. The calculation and comparison using a spreadsheet.
4. The determination of the conversion factors.

Obtaining Actual Payment Information

Prior to developing your RVU-based charge master, you need to obtain data from insurance companies regarding their "allowables" where possible and information from actual remittance advices "Explanation of Benefits (EOB)." To accomplish this, you should take two approaches.

First, you can obtain a schedule of insurance company allowables by requesting the fees they pay for usually your top 25 selected procedures. You can do this by preparing a form letter asking for their allowables which includes a listing of your top 25 procedures with CPT-4 code, your current fee, and a blank space for their allowable. You can use this same form and either mail or fax to each insurance carrier. This should be done at least annually for the practice.

Second, you should also review the actual remittance advices received from all the carriers for which you generate at least 5% of your business. This can be done by developing a spreadsheet approach listing vertically the CPT-4 code, description, and your current charge. Across the horizontal axis will be listed each one of the major carriers. Your billing staff will list from the EOBs the allowable by CPT-4 code for your same top 25 procedures. This annual review will give you the actual allowables for your major carriers and is a significant cross-check to your form letter requesting third-party allowables.

Utilizing the "80/20" Rule

While each practice should update their pricing schedule utilizing all CPT-4 codes, a valuable shortcut is utilizing the "80/20" rule; that is, 80% of your revenue is usually generated by approximately 20% of your procedures. From your year-to-date production analysis report, or your most recently completed fiscal year report, you can identify those CPT-4 codes which generate 80% of your practice charges (or collections, if available). This shortcut allows you to develop your new pricing schedule very quickly without having to go through several hundred CPT-4 codes in your charge master. However, eventually you should perform this exercise utilizing your entire CPT charge master.

Continued on page 288

Using Relative Value Units to Develop

Exhibit 1

		(C)	(D)	(E)	(F)	(G)
CPT-4	Description	Charge	RVU	Frequency 12 Mo. End 12/31/95	Medicare Allowable (Dx$38)	Practice Cost (Dx$44)
93510-26	Left heart cath	$700.00	7.70	338	$292.60	$338.80
93545	Select coronary angio	400.00	3.07	552	116.66	135.08
92982	PTCA (single vessel)	2,500.00	27.55	131	1,046.90	1,212.20
93307	2-D echo, M mode	400.00	5.97	1,115	226.86	262.68
93325	Doppler color flow map	300.00	3.15	1,211	119.70	138.60
93543	Select lt vent/atrial	200.00	1.60	367	60.28	70.40
93015	Treadmill	300.00	3.32	779	126.16	146.08
93350	Stress echo	550.00	7.26	283	275.88	319.44
93556-26	Angiography interp-pul	200.00	1.37	554	52.06	60.28
99231	Hospital care-focused	50.00	0.93	1,444	35.34	40.92
784655-26	SPECT	200.00	2.24	538	85.12	98.56
93555-26	Angiography interp-pul	200.00	1.13	372	42.94	49.72
93320	Spectral-Doppler echo	300.00	2.83	578	107.54	124.52
99253	Initial consult-detail	140.00	2.64	450	100.32	116.16
99232	Hospital care-expanded	70.00	1.38	1,427	52.44	60.72
99212	Established patient-fo	35.00	0.68	1,433	25.84	29.92
99243	Consultation-detailed	140.00	2.57	286	97.66	113.08
99213	Established patient-ex	55.00	0.97	1,037	36.86	42.68
99223	Initial adroit, "high"	200.00	3.82	206	145.16	168.08
93880	Carotid duplex (complex)	400.00	4.87	113	185.06	214.28
35474	Angioplasty, fem-pop	1,500.00	18.89	16	717.82	831.16
93925	Duplex scan, L.E. arter	400.00	4.87	73	185.06	214.28
93224	Holter monitor	320.00	4.92	99	186.96	216.48
93018	Treadmill reading & interp	75.00	0.71	426	26.98	31.24
93526-26	Combined right & left cath	1,100.00	11.96	38	454.48	526.24
Grand Totals						

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Spreadsheet Methodology

The spreadsheet illustrates the layout and methodology to calculate a new fee schedule, as well as the potential additional revenue to be generated. Based upon your collection percentage, a component of this revenue should be converted into cash receipts (Exhibit 1).

While the spreadsheet utilizes an average Medicare allowable of $38, there are actually three published Medicare conversion factors: surgical, $40.7982; primary care, $35.4173; and other nonsurgical services, $34.6293. The annual updates are published each December in the *Federal Register* (12/08/95, page 63189 for 1995).

An important additional step in this process is to compare the proposed new fee to the schedules of allowables and/or remittance advices from the various third-party payors to ensure the proposed fee does not fall below any current remittances by third-party payors. Otherwise, the revision to your charge master could result in lost cash flow. In those instances, you need to review your proposed price to recognize current third-party remittances.

By utilizing this process, you can develop a pricing schedule which has a logical and consistent basis and ensures your price is set at a level which recognizes your practice costs and a fair return.

Your Pricing Schedule Charge Analysis

(H)	(I)	(J)	(K)	(L)	
Conversion Factor	New Fee (DxH)	Fee Increase (Decrease) (I-C)	Total Charges Revised (IxE)	Current (CxE)	Revenue Gain/Loss (K-L)
$90.00	$693.00	($7.00)	$234,234.00	$236,600.00	($2,366.00)
90.00	276.30	(123.70)	152,517.60	220,800.00	(68,282.40)
90.00	2,479.50	(20.50)	324,814.50	327,500.00	(2,685.50)
90.00	537.30	137.30	599,089.50	446,000.00	153,089.50
90.00	283.50	(16.50)	343,318.50	363,300.00	(19,981.50)
90.00	144.00	(56.00)	52,848.00	73,400.00	(20,552.00)
90.00	298.80	(1.20)	232,765.20	233,700.00	(934.80)
90.00	653.40	103.40	184,912.20	155,650.00	29,262.20
90.00	123.30	(76.70)	68,308.20	110,800.00	(42,491.80)
55.00	51.15	1.15	73,860.60	72,200.00	1,660.60
90.00	201.60	1.60	108,460.80	107,600.00	860.80
90.00	101.70	(98.30)	37,832.40	74,400.00	(36,567.60)
90.00	254.70	(45.30)	147,216.60	173,400.00	(26,183.40)
90.00	237.60	97.60	106,920.00	63,000.00	43,920.00
55.00	75.90	5.90	108,309.30	99,890.00	8,419.30
55.00	37.40	2.40	53,594.20	50,155.00	3,439.20
55.00	141.35	1.35	40,426.10	40,040.00	386.10
55.00	53.35	(1.65)	55,323.95	57,035.00	(1,711.05)
55.00	210.10	10.10	43,280.60	41,200.00	2,080.60
90.00	438.30	38.30	49,527.90	45,200.00	4,327.90
90.00	1,700.10	200.10	27,201.60	24,000.00	3,201.60
90.00	438.30	38.30	31,995.90	29,200.00	2,795.90
90.00	442.80	122.80	43,837.20	31,680.00	12,157.20
90.00	63.90	(11.10)	27,221.40	31,950.00	(4,728.60)
90.00	1,076.40	(23.60)	40,903.20	41,800.00	(896.80)
			$3,188,719.45	$3,150,500.00	$38,219.45

The Art of the Conversion Factor

The most critical component in the process is developing (estimating) the conversion factor to be used to develop your new prices. While there are a number of factors to be considered in developing the conversion factor(s), two are of importance. These are:

1. The conversion factor should be developed which results in a price at least 10-15% above the highest allowable for that CPT-4 code.
2. The practice should consider whether to use a single conversion factor or to use two conversion factors; one for the evaluation and management codes and a second, higher conversion factor for the procedure codes. Alternatively, some practices prefer to use multiple conversion factors: i.e., for E & M, procedures, surgeries, and lab and radiology.

Conversion Factor Worksheet

Utilizing a two-tiered conversion factor recognizes the historical third-party basis of paying higher for procedures than for patient visits. The conversion factor schedule shown illustrates an overall approach utilizing both the Medicare conversion factor and your practice's cost per procedure to assist you in looking at a range of possible conversion factors appropriate for your practice. The Conversion Factor Worksheet also assists you in determining a new C.F.

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by looking at percent multiples of the Medicare C.F. and/or your practice's cost per RVU.

By utilizing the commercial spreadsheet method detailed in Exhibit 1, you can turn a number of scenarios with minimal additional work by playing "what if" with various factors/cell entries. This will enable you to see the revenue impact of the different conversion factors on the practice. After analyzing the various conversion factors in parallel with third-party allowables and third-party remittance advices (EOBs), you may select a conversion factor or factors and update and/or refine the pricing of services accordingly.

Exhibit #2 Conversion Factor Worksheet

Multiple	Medicare C.F. @$38	Cost/RVU @$44
125%	$ 47.50	$ 55.00
150%	$ 57.00	$ 66.00
175%	$ 66.50	$ 77.00
200%	$ 76.00	$ 88.00
225%	$ 85.50	$ 99.00
250%	$ 95.00	$ 110.00

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Prevalence and Implications of Perinatal Substance Use in Missouri

Maureen E. Dempsey, MD, FAAP, Tricia Schlechte, RN, MPH, Joseph W. Stockbauer, MD
Wayne F. Schramm, MA and Paul L. Cary, MS

A study was conducted to determine the prevalence of perinatal substance use in Missouri. The population sample studied was selected according to a multi-stage probability-proportional-to-size sampling. The weighted prevalence for perinatal exposure to alcohol, tobacco or illicit substances was 31.9%, 10.8% for illicit substances, 21.9% for tobacco use, and 7.9% for self-reported alcohol use. In 1993, an estimated 23,925 perinatal exposures to licit and illicit substances occurred.

The perinatal effects of substance use are well documented and include preterm labor, low birth weight, prematurity, congenital anomalies, fetal distress, stillbirth, cerebral infarction, mental retardation and other neurobehavioral effects.[1-16] These effects are not necessarily drug-specific.[13,17] Indirect effects result from risk-taking lifestyles, poor nutrition, inadequate weight gain, and absent or inadequate prenatal care.[13,16,18-20]

National estimates of substance abuse in pregnancy range from 5% to 16%.[8,21-23] Many studies were limited to minority women, women of low socioeconomic status, and those receiving prenatal care in public health clinics.[21,24-27] Studies conducted in large, urban hospitals that serve poor and ethnically diverse populations find high rates of illicit drug use.[28-30] Studies in suburban and rural areas[31,32] also reveal similar prevalence estimates.

The largest population-based, epidemiological study was conducted in California, which indicated an overall statewide prevalence of 5.2% for illegal drugs, with an estimated prevalence of alcohol use of 6.7%.[23] In South Carolina, a recent study revealed 12.1% of pregnant women used alcohol or other substances during pregnancy.[33] Rhode Island performed peripartum testing for illicit substances only and arrived at a prevalence rate of 7.5%.[22] Although these rates are reasonably consistent, significant variation existed between study designs, analytical methods and substances included in the determination of overall prevalence, making it difficult to compare results.

Peripartum testing is limited by a narrow window of detection for most substances, poor predictive value for positive results for substances of low prevalence in the population being assessed, and the inability to address **patterns** of substance use. Positive results may only reflect drug usage in the hours to days immediately preceding delivery.[26,34,35] Studies utilizing meconium analyses report the ability to detect substances used several weeks prior to delivery, which affords a more accurate index for drug use during pregnancy.[26,36-40] Few large studies compare detection of substances in both urine and meconium[33] and no **statewide** study has utilized paired maternal urine and infant meconium.

Methods

A statewide sample of peripartum women was secured utilizing a multi-stage probability proportional to size sampling design.[41] Missouri's 67 nonmilitary hospitals that experienced a minimum of 200 deliveries in 1991 constituted the sampling frame. These hospitals represented approximately 95% of the Missouri births recorded during that year.

The state was divided into three major regions. Within each region, probability proportional to size sampling was performed to randomly select eight hospitals from the St. Louis metro region, five from the Kansas City metro region and nine from outstate. In each region, one public hospital that delivered a large proportion of low income women was included in the study.

The study sample represented 67.1% of the recorded births and fetal deaths for the hospitals involved, for their respective study time periods. To ensure that the final realized sample was representative of the defined population, a comparison was made with recorded birth and fetal death records for that time period with regard to the distribution of race, age, Medicaid status and lack of prenatal care. The final realized maternal sample size was 2,213, with 2,008 paired maternal/infant samples.

Data were collected between February and July, 1993. The study population included all women admitted consecutively for delivery at each of the participating hospitals, with pregnancies of 20 weeks or more gestation, and their infants. Each hospital initiated sample collection on a specified date with significant overlap for collection periods among hospitals. Potential seasonal variations were not addressed.[40]

A portion of the routine urine specimen and the infant's meconium stool were obtained for analysis. Demographic data, obstetrical history, including self-reported use of alcohol, tobacco and other drugs (licit and illicit) during pregnancy, prenatal care status and delivery information were abstracted from the hospital medical record. Additional information included delivery outcome, birth weight, estimated gestational age, and prescription medications.

Urine and Meconium Analysis

All specimens were analyzed in a laboratory certified by the National Institute on Drug Abuse (University of Missouri - Toxicology Laboratory, Columbia, MO). Laboratory personnel received specimens labeled only with the coded identifiers.

Meconium was extracted by placing 500 mg of sample into a 1.5 mL micro centrifuge tube, adding 500 *u* L of methanol and vortex mixing for 1.0 minute. Samples were centrifuged at high speed and the supernatant fluid was utilized for analysis. Urine samples were analyzed directly, without pretreatment. Detailed information regarding methods of analyses and cutoff concentrations utilized are available from the author.

The initial assays for all substances utilized enzyme immunoassay (EIA) or fluorescent polarization immunoassay (FPIA) techniques. All substances, except cotinine, were assayed utilizing Syva® EMIT d.a.u.™ drug testing reagent system, according to manufacturer's directions. These were performed on a Boerhringer Mannheim Hitachi 704 automated analyzer. The Abbot Amphetamine/Methamphetamine II assay was employed as a secondary immunoassay screen.

The Abbot TDx TM Cotinine assay was utilized to determine the smoking status of the study participants. All Abbott procedures were followed. For all substances, samples producing results less than the established cutoff concentration by either EIA or FPIA were considered negative. If the initial screening assay yielded results at or near the cutoff concentration, the samples were subjected to Gas chromatography/mass spectrometry, utilizing an Hewlett-Packard 5970 Mass Selective Detector.

Statistical Analysis

Expansion weights were developed at the hospital level to represent that hospitals' deliveries for two years and to account for over/undersampling. Post-stratification was utilized to conform the sample's racial (black, non-black), birth weight (LBW, not LBW) and pregnancy outcome type (live birth, fetal death) distribution of deliveries to those of the population in the region and state for 1991-1992. SUDAAN (SUrvey DAta ANalysis)[42] was used to calculate the weighted prevalence estimates and standard errors, taking the sampling design into account.

Results

Utilizing chart abstraction for alcohol and urine analysis for all other substances, the overall estimates of statewide prevalence of any (licit and illicit) substance use during pregnancy was 31.9%. This estimate includes all of the illicit substances, plus alcohol and tobacco.

The overall estimate of the percentage of women or infants testing positive for one or more illegal substances are presented in Table 1. Based **solely** upon maternal urine analyses, the overall prevalence of illegal drug usage was 10.8%. Infant meconium analyses revealed an overall prevalence of illegal drug use of only 6.2%. When both methods are utilized (urine only positive, meconium only positive, plus all paired positives) the prevalence was 13.0%. In Table 1, it is important to note that the acquired prevalence rates for opiates, benzodiazepines, amphetamines and barbiturates may be unreliable, due to unreported usage of prescribed medications.

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Table 1. Overall Prevalences of Antepartal Drug Exposure based on Different Sources (Missouri 1993 Perinatal Substance Abuse Study)

	Chart %/±*CI**	*Urine* %/±*CI*	*Meconium* %/±*CI*
Alcohol	7.9	-	-
	1.3		
Tobacco	22.5	21.9	-
	3.4	3.6	
Marijuana	1.3	4.0	1.9
	0.5	1.1	0.8
Cocaine	1.1	1.3	1.4
	0.5	0.6	0.7
Opiates	-	2.2	0.3
	1.0	0.2	
Benzodiazepines	-	1.3	0.16
	0.6	0.2	
Amphetamines	0.1	0.2	0.1
	0.2	0.2	0.2
Barbiturates	-	3.4	2.7
	1.1	0.9	
Phencyclidines	-	0.02	0
	0.04	-	
Any drug	25.7	28.1	6.2
	3.4	3.7	1.4
Illegal drugs	2.0	10.8	6.2
	0.7	2.5	1.4
N	2,213	2,213	2,008

**CI - confidence interval*

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The prevalence of marijuana usage based upon urine analysis was 4.0%, which was considerably higher than the prevalence of 1.9% in meconium. For cocaine, there was no difference between the urine or meconium analyses (1.3% vs. 1.4%).

Table 2 compares the prevalence of marijuana, cocaine and barbiturates for both urine and meconium analysis. Based upon the overall prevalence, paired sampling yielded the best results for cocaine. Marijuana was most frequently detected only in the urine and rarely detected **only** in the meconium. Barbiturates were also detected most frequently in the urine alone which may represent recently administered or consumed medications. Barbiturates which were detected only in the meconium may signal illegal use earlier in pregnancy or use of prescription medications that were not recorded. To simplify the remainder of the presentation, the subsequent data presented, except alcohol, were obtained from urine toxicological analyses.

Table 2 - Prevalence of Marijuana, Cocaine and Barbiturates Antepartal Drug Exposure Based on Meconium and Urine Testing (Missouri 1993 Perinatal Substance Abuse Study)

	Marijuana	*Cocaine*	*Barbiturates*
Meconium (+) Only	0.23	0.34	1.69
Urine (+) Only	2.39	0.23	2.78
Both Positive	1.64	1.09	1.32
Neither Positive	95.74	98.34	94.21
Total	100	100	100

N=2,008

The prevalence of alcohol usage was 7.9%, as measured by chart abstraction. Prevalence of tobacco usage did not differ greatly between urine cotinine, 21.9% and chart abstraction, 22.5%.

Except for cocaine, prevalence of substance use varied little by race. White women had higher prevalence rates for tobacco (22.8 ± 4.3 vs. 18.8 ± 4.2) and marijuana use (4.3 ± 1.4 vs. 3.1 ± 1.1), while black women had higher prevalence rates for alcohol (10.0 ± 2.0 vs. 7.4 ± 1.5) and cocaine (5.9 ± 2.0 vs. 0.3 ± 0.2). The only statistically significant ($P<0.05$) difference between the groups was for cocaine usage. The prevalence rate among black women was nearly twenty times higher than the corresponding rate for white women.

Prevalence estimates in relation to maternal age are presented in Table 3. The lowest drug prevalence estimates were noted for adolescents 12-19 years of age. Alcohol usage increased with age, with the prevalence estimates for the 25-29 and 30-44 age groups being significantly higher than the corresponding rates for ages 12-19. In addition, the prevalence of alcohol usage for women ages 30-44 was significantly higher than for women in the 20-24 age group.

The estimate of prevalence of cocaine usage among all women in the study initially increases with the age of the mother, from 0.3% for adolescents ages 12-19, to 2.0% for women in the 25-29 age range. The prevalence estimates for women in the 25-29 and 30-44 age groups are significantly higher than the prevalence in adolescents. These trends by age for cocaine usage do not accurately represent white women, due to their low prevalence. For black women, the estimate of prevalence of cocaine usage increases with the age of the mother, from a low of 0.5% for adolescents to a high of 13.5% for women in the 25-29 year old range. Prevalence then decreases to 11.7% for women 30-44 years of age.

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Table 3. Weighted Age-Specific Prevalence of Antepartal Drug Exposure Based on Urine Testing (Missouri 1993 Perinatal Substance Abuse Study)

Drug	*Ages 12-19 (1)*		*20-24 (2)*		*25-29 (3)*		*30-44 (4)*	
	Percent	*CI(±)*	*Percent*	*CI(±)*	*Percent*	*CI(±)*	*Percent*	*CI(±)*
Alcohol*	4.0	2.1	6.6	1.8	7.9(1)	2.1	11.4(1,2)	3.4
Tobacco	17.1	4.8	25.2(1)	4.8	22.0	5.3	20.7	4.4
Marijuana	3.4	2.3	5.2	2.4	3.5	1.9	3.8	1.8
Cocaine	0.3	0.4	0.9	0.6	2.0(1)	1.3	1.5(1)	1.0
Sample Size	404		666		564		566	

*From chart review.

The number(s) in parentheses indicate the group with prevalence estimates significantly lower (P<0.05) than the estimate for the group shown at the head of the column.

Table 4. Weighted Prenatal Care-Specific Prevalence of Antepartal Drug Exposure Based on Urine Testing (Missouri 1993 Perinatal Substance Abuse Study)

	Trimester Care Began									
Drug	*First (1)*		*Second (2)*		*Third (3)*		*No Care (4)*		*Unknown Care (5)*	
	Percent	*CI(±)*	*Percent*	*CI(±)*	*Percent*	*CI(±)*	*Percent*	*CI(±)*	*Percent*	*CI(±)*
Alcohol*	6.6	1.5 (1)	10.1 (1,2,3,5)	2.3	12.2	7.9	33.8	12.6	9.1	5.1
Tobacco	18.9	3.8 (1)	27.0 (1,2,3,5)	5.2	24.2 (1)	10.1	49.2	12.9	32.57.8	
Marijuana	3.1	1.3 (1)	6.4	2.5	5.3	4.4	10.3	9.0	5.9	3.4
Cocaine	0.5	0.4 (1)	1.6 (1,2,3,5)	1.6	5.9	4.2	23.3	12.5	1.9	1.6
Sample Size	1,476		390		94		58		195	

*From chart review.
The number(s) in parentheses indicate the group with prevalence estimates significantly lower (P<0.05) than the estimates for the group shown at the head of the column.

Table 5. Weighted Birth Weight-Specific Prevalence of Antepartal Drug Exposure Based on Urine Testing by Race (Missouri 1993 Perinatal Substance Abuse Study).

	All Races				*White*				*Black*			
	LBW		*Not LBW*		*LBW*		*Not LBW*		*LBW*		*Not LBW*	
	%	*CI*	*%*	*CI*	*%*	*CI*	*%*	*CI*	*%*	*CI*	*%*	*CI*
Alcohol*	16.5**	4.5	7.2	1.3	9.4	5.9	7.2	1.5	23.5**	10.8	7.9	2.0
Tobacco	32.9**	10.3	21.0	3.7	30.6	13.1	22.3	4.4	36.5**	16.5	16.1	3.8
Marijuana	8.2**	4.3	3.7	1.0	10.5**	6.1	.9	1.3	5.1	5.9	2.8	0.9
Cocaine	5.0**	3.3	1.1	0.5	1.2	2.3	0.2	0.2	12.3**	7.3	5.0	1.7

*From chart review.
** Signficiantly higher (P<0.05) than the not LBW group.

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The highest prevalence rate for marijuana was noted for women in the 20-24 year old age range, with no significant trend according to age. The highest prevalence for tobacco use also was noted for the 20-24 age range, which was significantly higher than the 12-19 age group.

Table 4 shows the relationship between level of prenatal care and substance use. For alcohol, tobacco, cocaine and marijuana, usage is most prevalent for women who received no prenatal care. Of those women who did not receive prenatal care, over one-third admitted using alcohol and nearly one-half used tobacco, with nearly one in four using cocaine and over one in ten using marijuana. Alcohol, tobacco and cocaine usage were significantly higher for women having no prenatal care than for those receiving some prenatal care, regardless of trimester of entry. For all substances, entry into care in the first trimester was associated with the lowest prevalence rates. The prevalence estimates for alcohol, tobacco and marijuana for first trimester entry into care were significantly lower than those for entry during the second trimester.

The effects of substance use on birth weight overall and by race are presented in Table 5. The prevalence estimates for all four substances are significantly higher for women who delivered infants weighing <2500 grams (low birth weight) than for women delivering heavier infants. One in three women delivering low birth weight infants used tobacco, nearly one in six used alcohol, one in twelve used marijuana, and one in twenty used cocaine. For white women, only the prevalence estimate for marijuana was significantly higher for women delivering low birth weight infants. However, for black women the prevalence estimates for alcohol, tobacco and cocaine were significantly higher for women having low birth weight infants.

Prevalence estimates also were calculated for expected payment source, region of residence, prior live births and prematurity. The prevalence estimate for tobacco was significantly higher ($P<0.05$) for the Medicaid and self-pay groups than for women who had private insurance.

Prevalence estimates for marijuana and cocaine also were significantly higher ($P<0.05$) for Medicaid than for the private insurance group. Significantly higher ($P<0.05$) prevalence estimates for alcohol and cocaine were found for the St. Louis and Kansas City metro areas than for outstate Missouri. Women having three or more previous live births had significantly higher prevalence estimates for tobacco and cocaine than women having fewer previous live births. Alcohol and cocaine use were significantly higher in deliveries that occurred prior to the 37th completed week of gestation.

The study results were utilized to estimate the number of substance-exposed infants born during 1993, when approximately 75,000 Missouri women gave birth. The totals were 23,925 infants estimated to have been exposed to **any** substance, licit or illicit: 16,425 to tobacco; 8,100 exposed to one or more illicit drugs; and 5,925 exposed to alcohol.

Discussion

Missouri law[43] requires that all prenatal care providers assess pregnant women for the risk and current use of alcohol, tobacco and other substances, and to provide education regarding their effects on pregnant women and their fetuses. Verification of assessment and education must be documented in the prenatal record. The information recorded in the prenatal record is generally transferred to the hospital medical record, at the time of delivery. Self-reported maternal alcohol and tobacco use are recorded on birth certificates, as well. Concerns regarding self reported substance use have been documented to include denial of addictive behavior, fear of discovery, prosecution, or shame.[28,30-32,39,40] However, the potential exists for more accurate reporting of **licit** substances such as tobacco, as demonstrated by our birth certificate information.

Comparison of our results with those from other states serves to highlight the difficulties posed by variations in design and methodology. Researches in California[23] and South Carolina[33] relied upon urine toxicology for the estimation of alcohol prevalence, while we relied upon data abstracted from patient records. Our results are reasonably consistent with the results reported by California, however, the prevalence estimate in South Carolina appears somewhat low and may represent an underestimation, given the extent of alcohol use among women of child-bearing age in general. The Rhode Island study evaluated only illicit substances.[22] California relied upon self report for tobacco estimates, while South Carolina and Rhode Island did not include tobacco among the substances evaluated in their studies. These variation become critical when the overall prevalence of substance use is compared between states or other studies. The high prevalence of 31.9% in Missouri reflects **any** substance exposure during pregnancy including alcohol, tobacco and illicit substances.

Analysis of maternal urine yields results that may be affected by variations in metabolism and half-life of the substances in question.[26,34,35] Meconium has been reported to be easier to collect and to provide better results than either urine or the combination of urine analysis and self report.[38-40]

The highest overall prevalence rates for illicit substances were obtained utilizing positives in paired urine or meconium (positive results in urine with negative results in meconium and vice versa). This implies that even with pairing of samples there is no assurance that either avenue of assessment is sufficient to reliably report the true positives and certainly raises questions regarding false negatives.

The chronicity, amount, and timing of substance use affects the results obtained from maternal urine. It is less clear with regard to analysis of meconium. Meconium accumulates throughout gestation and excretion generally does not begin until the time of delivery or soon thereafter. Meconium serves as a repository of metabolites acquired through ingestion of amniotic fluid and direct deposition from bile. Questions regarding fetal metabolism of substances, rate of development and accumulation of meconium, effects of early versus late use of substances during pregnancy upon deposition and the rate of fetal gut motility or transit time, remain unanswered. Meconium may be reliable for certain substances such as cocaine, but appears to be less so for marijuana. These issues require further clarification. Marijuana is stored in adult fatty tissues for variable periods of time, based upon dosage and chronicity of use.[44-46] Storage in fetal fatty tissue, accompanied by variable release, would theoretically alter deposition in meconium.

One large epidemiological prospective study[40] concludes that infant meconium is superior to infant urine in detecting maternal substance use. In an earlier study,[37] a very high concordance between maternal urine and infant meconium was shown. However, the sample size was small (n = 28), their subjects were neonates born to mothers **suspected** of substance use and only one of 28 samples was positive for marijuana. In contrast, a large study[33] that assayed paired maternal urine and infant meconium in three large hospitals, found a higher prevalence of both marijuana and cocaine in meconium than their prevalence based upon urine results. Based upon our study and the above unresolved issues, it may be premature to designate meconium as the "gold standard" for perinatal substance use detection. Reliance solely upon this technique for detection does not afford the opportunity for prevention and early intervention.

The results of our study have several major clinical and public health implications. The high prevalence of overall substance use in pregnancy for both legal and illegal substances (31.9%) suggest that education and prevention-based activities must be developed, culturally tailored, and fostered at the community level with broad-based support. Substance use increases with age for most substances, suggesting that educational interventions must target both adolescents and young adults. These interventions must counterbalance the very effective marketing campaigns for substances that target our youth.[47-49] Intervention opportunities in early adolescence appear promising because early adolescents, especially black teenagers, have lower rates for drug and tobacco use.[50,51]

Greater emphasis must be placed upon smoking cessation programs for pregnant women. Several recent studies reveal encouraging results.[52,53] Altering smoking behaviors in pregnant women may require intensive intervention in order to achieve higher cessation rates.[54] Current residential and outpatient programs for pregnant women are limited in number and primarily address illicit substances.

All of the substances evaluated in our study adversely affected birth weight. For black women, the prevalence estimates for alcohol, tobacco and cocaine were significantly higher in the low birth weight group, as compared to their not low weight counterparts. The only statistically significant difference noted for the white population was with regard to marijuana. Furthermore, while blacks represent 17% of Missouri births, they represented over 80% of the cocaine usage. These results certainly address the need for culturally sensitive, targeted interventions, as the effects of both licit and illicit substances may be particularly devastating to blacks. However, whites represent the majority of Missouri births and in terms of absolute numbers, more white infants were exposed to alcohol, tobacco, and marijuana.

It is important to note that the prevalence rates for alcohol and tobacco were significantly higher than those for the illegal substances cocaine and marijuana. Of all substances studied, tobacco had the highest prevalence rate and is known to be used frequently in conjunction with other substances. The perinatal

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effects of nicotine are similar **in mechanism** to those of cocaine. As with cocaine, stimulation of the sympathetic nervous system and catecholamine release results in uterine vasoconstriction and fetal hypoxia. In addition, carbon monoxide binds directly to hemoglobin and decreases oxygen unloading from the mother to the fetus and the fetus to the tissues.[52,55-59] The **pattern** of daily repetitious nicotine usage suggests that the fetus is subjected to multiple, frequent episodes of hypoxia.[58] Smoking is most strongly associated with post-neonatal mortality[5,60] and an increased risk of dying from SIDS.[60,61] Birthweight is markedly affected by tobacco use[5,52] and in our survey, one in three women delivering low birthweight infants used tobacco.

The effects of fetal alcohol exposure are well documented.[1-3,62-64] Utilizing low birth weight as a measure of fetal well being, one in six women delivering a low birthweight infant used alcohol in our study. Growth retardation strongly correlates with heavy alcohol use, regardless of smoking status.[2,64] In addition, the prevalence of alcohol was higher in pregnancies where delivery occurred prior to the 37th week and over one-third of the women who received no prenatal care used alcohol.

Lack of prenatal care is known to impact birthweight, prematurity, morbidity and mortality.[18,19] Lack of prenatal care and late entry into care were strongly associated with substance use in our study. The attendant health risks related to substance use[13,19,65,66] and their potential impact upon perinatal care, early identification of substance users, and early intervention. MacGregor et al[19] found that women receiving little or no prenatal care had significantly increased perinatal morbidity, compared to those who received comprehensive prenatal care, despite the continued use of cocaine throughout pregnancy. Adequate prenatal care may improve outcomes through better nutrition, better social services, decrease in substance use, and intensive antenatal surveillance.

Our study results highlight the need for a balanced, broad-based approach to substance use during pregnancy in Missouri. Professional education regarding risk factors related to substance use during pregnancy must address the need for **early** and **repeated** assessments and the necessity of early intervention. Treatment and other targeted interventions for regional or ethnic variations in substance use can be established based upon this study.

The impact of substance use upon perinatal outcome has been well established by earlier studies. The potential impact for the nearly 24,000 Missouri infants exposed per year to substances during pregnancy commands attention to the development of appropriate public policy and professional intervention.

Acknowledgments

We extend special thanks to Syva Company and Abbott Laboratories for their generous donation of all reagents utilized for specimen analyses, to Nela Beetem, RN, for the provision of professional education and the numerous professionals who volunteered for the prevalence study advisory committee, hospital staff members, toxicology staff, and to Linda Krogstad for her secretarial support.

This study was supported by general revenue funding, appropriated by the Missouri General Assembly and in part from funding received through the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse.

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Surgical Management of Chronic Ulcerative Colitis

José M. Dominguez, MD, Peter M. Sagar, FRCS, Santhat Nivatvongs, MD

Chronic ulcerative colitis (CUC) is an inflammatory disease of the colon and rectum. The etiology of this condition is unknown. Factors implicated in its development include immunologic processes, genetic predisposition, bacterial and viral infections, and dietary substances. The premalignant nature of CUC mandates close surveillance, especially after 10 years of disease.[1-4] Surgery plays an important role in both preventing and treating malignancy in CUC. Multiple other situations, such as failure of medical treatment, warrant consideration for surgical management.

Surgical options in CUC include proctocolectomy with Brooke ileostomy, abdominal colectomy with ileorectal anastomosis, proctocolectomy with Kock pouch, and restorative proctocolectomy with ileal pouch-anal anastomosis (IPAA). The choice of operation must be tailored to the patient. Important factors to be considered include age, associated medical conditions, body habitus, presence of malignancy, and quality of the anal sphincter. Extensive preoperative education is required which should include access to patients previously operated upon and enterostomal therapists.

The decision to offer surgical options to a patient with CUC requires cooperation between the treating gastroenterologist and the surgeon. The purpose of this paper is to review indications for surgery, operative procedures, and special circumstances important when treating CUC.

Indications for Surgery

The indications for surgical intervention are given in Table 1. In certain patients, the risks and benefits of continued medical treatment must be carefully weighted against surgical management. In other cases, such as massive hemorrhage, perforation, high-grade dysplasia, and carcinoma the decision to operate is less difficult.

Table 1. Indications for Surgery in Chronic Ulcerative Colitis

Acute Indications:
- **Fulminant colitis**
- **Toxic megacolon**
- **Perforation**
- **Massive hemorrhage**

Chronic Indications:
- **Unresponsive to medical management**
- **Excessive steroid dose**
- **High-grade dysplasia**
- **Dysplasia-associated lesion or mass (DALM)**
- **Carcinoma**
- **Fear of carcinoma**
- **Severe extraintestinal manifestations**
- **Growth retardation**
- **Chronic bleeding requiring transfusion**
- **Large bowel obstruction**

Fulminant Colitis

Fulminant colitis is a severe attack of colitis which may be the first manifestation of CUC. Patients present with bloody diarrhea, abdominal pain and fever. Signs of systemic sepsis such as tachycardia, hypotension and leukocytosis may also occur. Massive hemorrhage may complicate CUC and, in particular, fulminant colitis. Maximal medical support is the standard initial treatment if there are no signs of peritonitis. Early institution of total parenteral nutrition is also recommended. Failure of clinical improvement in 24 to 48 hours or deterioration

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in the medical condition is a strong indication for operation. Early surgical intervention has been shown to minimize the risk of complications.[5]

Toxic Megacolon

Toxic megacolon is the acute dilation of a segment of the colon with associated toxicity. It may complicate a case of fulminant colitis or be the first manifestation of CUC. Hypokalemia, antidiarrheal medications and barium enema examinations have been reported to predispose to development of toxic megacolon.[6] Aggressive medical management is indicated initially including total parenteral nutrition, frequent position changes and nasogastric decompression. Frequent abdominal examination and radiographs are needed to exclude perforation. The majority of patients are on steroids which can make physical assessment unreliable. Failure to improve in 24 to 48 hours, deteriorization of clinical status and perforation are indications to operate. Surgery prior to perforation reduces mortality from 40% to 4%.[6]

Dysplasia and Cancer

The development of dysplasia, precursor to the development of a carcinoma, usually does not occur in the first 7 to 10 years of disease.[1-4] It is at that point where a program of endoscopic surveillance with multiple random and lesion directed biopsies must be instituted. Earlier surveillance may be indicated especially with a family history of colorectal carcinoma.

The architectural and nuclear changes in dysplasia have been standardized by the Inflammatory Bowel disease/Dysplasia Morphology Study Group.[1] An experienced gastrointestinal pathologist facilitates accurate diagnosis. Difficulty may arise differentiating regenerative changes secondary to the inflammatory process from dysplasia. Biopsy material may be classified as negative (normal mucosa, quiescent or active colitis), indefinite, low-grade dysplasia and high-grade dysplasia. The finding of high-grade dysplasia is an indication for resection. The finding of low-grade dysplasia and indefinite features warrant a step up in frequency of surveillance. Low-grade dysplasia in a patient with a strong fear of developing carcinoma may be an indication for surgery in select circumstances.

Dysplasia-associated lesion or mass (DALM) is the endoscopic finding of a mass, plaque or multiple closely related sessile polyps biopsied showing either low or high-grade dysplasia. The finding of DALM is an indication for surgery because a greater than 50% chance of the presence of a coexistent invasive carcinoma.

The long-term risk of developing colorectal carcinoma in CUC after 10 years of disease is 3%-10% and rises 1%-2% yearly.[1-4] The problem with the use of random endoscopic biopsies to detect dysplasia is the fact that up to 30% of carcinomas may have no dysplasia remote from the tumor.[8] Improved techniques to detect developing carcinomas will aid in timing operative intervention.

Table 2. Extraintestinal Manifestations in Chronic Ulcerative Colitis

Dermatologic
- **Erythema nodosum**
- **Pyoderma gangrenosum**

Opthomologic
- **Uveitis**
- **Iritis**

Rheumatologic
- **Peripheral arthropathy**
- **Sacroileitis**
- **Ankylosing spondylitis**
- **Rheumatoid arthritis**

Vascular
- **Thromboembolic disease**
- **Vasculitis**

Hepatobiliary
- **Primary sclerosing cholangitis**

Unresponsive to Medical Management

The majority of patients with CUC can be controlled by medical management. Salicylates and steroids are the most commonly used agents. Agents, such as cyclosporine, to alter the immune system may be employed in severe cases to induce remission. Clinical trials to evaluate agents which modulate the cytokine response are being undertaken. Prior to recommending surgery, a maximal trial of medical management is indicated. There are patients who require such excessive doses of steroids that surgery may be warranted.

Table 3. Comparisons of Operations for Chronic Ulcerative Colitis

Procedure	Fecal Continence Preserved	Permanent Stoma	Intubation Required	Residual Diseased Mucosa	Disadvantages
Ileal pouch-anal anastomosis	yes	no	no	no	frequent bowel movements, occasional fecal leakage, pouchitis
Kock pouch	yes	yes	yes	no	valve dysfunction, pouchitis
Ileorectostomy	yes	no	no	yes	risk of rectal carcinoma, proctitis
Brooke	no	yes	no	no	ileostomy bag required

Source: Modified from Kelly KA, Dozois RR. Chronic ulcerative colitis. In: Moody FG (ed). *Surgical Treatment of Digestive Diseases*, 2nd Edition. Year Book Medical Publishers, Chicago; 1990.

Patients who fail to respond to medical management should be offered surgical consultation to discuss options. Experimental protocols at inflammatory bowel disease centers should also be considered especially in the patient who is not emotionally ready for surgery.

Severe Extraintestinal Manifestations

One-third of patients with CUC suffer from extraintestinal manifestations (Table 2). With the exception of ankylosing spondylitis, rheumatoid arthritis and primary sclerosing cholangitis; the majority of extraintestinal manifestations of CUC respond to removal of the entire colon and rectum.

Growth Retardation in Children

Severe growth retardation is reported in children with CUC. The effect of chronic illness and steroid use contribute to this problem. In patients with growth retardation resection is advocated prior to the closure of epiphyseal plates.

Obstruction

Patients with CUC who develop large bowel obstruction are likely to have developed a colorectal carcinoma. The possible causes of obstruction include benign and malignant etiologies. Benign strictures may be the result of the CUC, diverticular disease and ischemia. In all cases of stricture formation a high index of suspicion of malignancy must be maintained.

Surgical Options

The choice of operation offered to a patient requires an understanding of the advantages and disadvantages of the four main surgical options (Table 3). Patient-related factors can then be evaluated and an appropriate operation be undertaken.

Proctocolectomy with Brooke Ileostomy

This procedure removes all diseased tissue with resection of the cecum, colon, rectum and anus with creation of a permanent Brooke ileostomy. All patients are suitable candidates for this operation irrespective of age or body habitus. However, obesity makes construction of a good Brooke ileostomy difficult. The

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combination of a good ileostomy and contemporary stomal appliances makes management of the effluent tolerable in most patients.

The problem of delayed healing of the perineal wound is well documented.[9] Intersphincteric perineal dissection improves the chance of primary healing. The anus and distal rectum are removed through a small skin incision with the dissection being carried out in the plane between the internal and external anal sphincter. This leaves the external sphincter and levator muscle complex available for closure.

Another disadvantage to this operation is the need for a permanent stoma which is incontinent of gas and stool. There are inherent stomal related complications such as peristomal dermatitis, prolapse and parastomal hernias. Despite the disadvantages, proctocolectomy with Brooke ileostomy remains a viable option in older patients who may not be candidates for the sphincter saving option, IPAA.

Abdominal Colectomy with Ileorectal Anastomosis

This procedure involves removal of the abdominal colon with creation of an ileorectal anastomosis. The diseased rectum remains in situ. There is no need for a stoma and the risk of bladder and sexual dysfunction secondary to pelvic nerve injury is low. The ability to make an ileorectal anastomosis requires a quiescent or minimally inflamed rectum if the procedure is to be successful.

The functional results are variable and depend on rectal compliance and the extent and activity of the CUC. Interval proctectomy may be required in up to 40% of patients and the risk of developing a rectal carcinoma is up to 15% at 30 years.[10-12]

Ileorectal anastomosis may be indicated in patients found to have metastatic colon carcinoma at the time of laparotomy. This obviates the need of a stoma in a patient with short-term survival. Also, a patient who is strongly against a stoma and is unwilling to take the very small but present risk of sexual dysfunction complicating proctectomy. Although quality of life is generally good, patients do not feel as if they are cured of CUC and may require chronic maintenance therapy to treat proctitis. The risk of subsequent development of rectal carcinoma also mandates regular endoscopic surveillance. Previous ileorectostomy does not proclude a future IPAA.

Proctocolectomy with Kock Pouch

The Kock pouch procedure involves a standard proctocolectomy with creation of an ileal pouch with a valve to render the pouch continent. The valve is created by intussuscepting the terminal ileum into the pouch. The exit spout leading to the pouch can be placed in an inconspicuous location on the lower abdomen. The pouch is emptied by tube intubation 2 to 4 times daily.[13] An external appliance is not needed.

The main problem with the Kock pouch is the high complication rate. Reoperation rates of 10% to 20% , particularly for valve dysfunction, is reported in series from experienced centers.[14,15] There is also a risk of pouchitis characterized by diarrhea, abdominal cramps and fever. Multiple variations of the Kock pouch have been described attempting to minimize the mechanical failures.

This procedure is suitable for patients who have previously undergone a proctocolectomy and Brooke ileostomy who wish conversion due to dissatisfaction with the ileostomy. Patients who are not candidates for IPAA due to poor anal sphincter function may also be considered candidates. A failed IPAA may be converted to a Kock pouch in certain cases. The procedure is not advisable in patients with previous small bowel resection due to the risk of developing a short bowel syndrome in the event of Kock pouch failure with subsequent excision.

Restorative Proctocolectomy with Ileal Pouch-Anal Anastomosis

IPAA is now the procedure of choice in most cases of CUC. This operation avoids the need of a permanent stoma and maintains the normal route of defecation. The procedure was first described by the late Sir Alan Parks of St. Mark's Hospital in London.[16] Since its creation, multiple modifications have been described to improve functional results.

This procedure begins with resection of the colon and rectum. The rectal mobilization is carried out close to the bowel wall thus minimizing the risk of bladder and sexual dysfunction. The ileal pouch is then constructed using one of the several available pouch designs. These include the J-pouch, S-pouch and W-pouch.[17,18] The ultimate choice of pouch design is largely the surgeon's preference. The J-pouch is the most commonly used in part due to the ease of construction.

The choice of anastomosis is controversial. There are two options: (1) a transanal mucosectomy with hand-sutured anastomosis between the pouch and the dentate line or (2) a double-stapled technique with anastomosis 2 to 3 cm above the dentate line preserving the anal transition zone. Proponents of the mucosectomy technique offer the following advantages: (1) all diseased mucosa is eliminated, (2) risk of cancer in persistent rectal mucosa is eliminated and (3) postoperative surveillance is not required. Advocates of the double-stapled technique suggest that it is technically easier and has better functional results. The latter point is hotly debated. To date, randomized and case control studies published show no functional differences between the two techniques.[19,20]

After completion of the anastomosis, a diverting loop ileostomy is usually fashioned. This entails a second, smaller operation 2 to 3 months later to restore intestinal continuity. There are select patients who have undergone a single-stage operation with acceptable results. This includes patients in good nutritional health and on very low dose or no steroids.

Patient selection for IPAA is very important. Patients less than 60 years of age are preferred. Those over 60 years of age are generally advised to undergo proctocolectomy with Brooke ileostomy. Exceptions have been made in extremely vibrant individuals with acceptable results. Extremely obese patients are advised to loose weight prior to operation. The ability of the ileal pouch to reach the anus for anastomosis is compromised with obesity. The anal sphincter needs to be of good quality. If there is any question, anal manometry should be performed. There are patients who with a severe flare of colitis have incontinence of liquid stool, but do have an adequate anal sphincter and are candidates for IPAA.

In experienced hands, the results with IPAA are good. Mortality is less then 1%. The most common complications of IPAA are small bowel obstruction, anal stricture, pelvic sepsis and pouchitis. The risk of bowel obstruction is approximately 10% and half of the cases require laparotomy with lysis of adhesions. The rate of obstruction is higher than that reported for proctocolectomy and Brooke ileostomy. Some degree of anal stricture may be found at the time of ileostomy closure. Gentle dilatation is the treatment. Predisposing factors include pelvic sepsis, anastomotic tension and ischemia. Overall the reported incidence is 38% of which the vast majority respond to dilatation.[21]

Pelvic sepsis is the dreaded complication with IPAA. Poor nutritional status and immunosuppressive mediations such as prednisone, cyclosporine and azotnioprine are predisposing factors. Many patients can be treated by CT guided catheter drainage and antibiotics. The functional outcome after IPAA complicated by pelvic sepsis is poor.[22]

Pouchitis is a condition characterized by increased stool frequency, bloody stools, abdominal cramps, abdominal pain and fever. The etiology is unknown. The incidence varies from 7% to 50% according to the definition of pouchitis used and the duration of follow-up.[23] At the Mayo Clinic, the cumulative risk of acute pouchitis was 15% at one year, 36% at five years, and 46% at 10 years.[24] Some have used this fact as a strong argument against their patients undergoing IPAA, but this seems unreasonable since the majority of patients with acute pouchitis have only one episode which responds promptly to a short course of antibiotics. Metronidazole is the treatment of first choice.[25] Many other treatments in refractory cases have been used such as ciprofloxacin, corticosteroids, amoxicillin/clavulinic acid, erythromycin, tetracycline, allopurinol, 5-aminoacetic acid, short-chain fatty acid enemas and cyclosporine retention enemas.

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It is rare that pouchitis is the cause of IPAA failure and excision.

The overall results of IPAA are very good. Patients generally have 4 to 7 bowel movements per day. They are able to differentiate gas from stool and importantly can defer defecation. The extreme urgency seen with a flare of CUC is no longer present. Quality of life in patients with IPAA is better than that of patients with Brooke ileostomy, Kock pouches and medically treated patients with CUC.[26,27] It is the combination of good functional results and quality of life which argues strongly in support of IPAA as the operative procedure of choice in CUC.

Special Circumstances

There are multiple situations in the surgical treatment of CUC which warrant special consideration.

Indeterminate Colitis

All attempts to differentiate CUC from Crohn's disease should be made preoperatively. This is important because IPAA and the Kock pouch should not be done for Crohn's disease. All endoscopic, radiographic and pathologic information should be reviewed carefully preoperatively. At the time of laparotomy frozen sections may be taken from the colon. In cases where there is convincing evidence of Crohn's disease, proctocolectomy with Brooke ileostomy or ileorectostomy should be done. If the diagnosis is in question the rectum can be left as a Hartmann's pouch and an ileostomy created. This leaves the option for future IPAA, ileorectostomy or completion proctectomy.

There are cases in which there are histologic features of both CUC and Crohn's disease which is termed indeterminate colitis. If these patients undergo IPAA, the functional outcome and failure rates are similar to "textbook" cases of CUC.[28,29]

Primary Sclerosing Cholangitis

Primary sclerosing cholangitis (PSC) is the most common hepatobiliary condition associated with CUC. Colonic and biliary epithelium share antigenic epitopes. PSC may lead to biliary cirrhosis and portal hypertension. Stomas of any kind, in particular ileostomies, should be avoided due to the development of stomal varices. Proctocolectomy with ileostomy is associated with an approximate 50% incidence of bleeding complications from the stoma and stomal varices.[30]

Given the opportunity, IPAA or ileorectal anastomosis are preferred over creation of stoma. Varices with IPAA although theoretically possible have not been reported. Patients with CUC and PSC treated by IPAA do have a higher incidence of pouchitis.[24]

Colon and Rectal Carcinomas

The finding of a colon or rectal tumor in a patient with CUC is unfortunate. Colon primary tumors of relative early stage (Duke's A or B) can be treated by proctocolectomy and IPAA, Kock pouch or Brooke ileostomy. Metastatic colon tumors to the liver should be treated by proctocolectomy with Brooke ileostomy or abdominal colectomy with ileorectal anastomosis. The treatment of patients who are lymph node positive (Dukes' C) is best by proctocolectomy and Brooke ileostomy. If the patient is very adverse to a stoma, IPAA could be carried out or the rectum could be divided at the pelvic floor leaving open the future option of a IPAA.

Rectal carcinoma in the middle and lower rectum is a contraindication for IPAA. A standard proctectomy is advisable and a permanent Brooke ileostomy. These patients are prone to local recurrence, thus radiation therapy may be required. Patients with upper rectal tumors may safely undergo IPAA, but in the case of a large, advanced tumor, proctocolectomy and Brooke ileostomy is advisable.

Emergency Operations

Fulminant colitis and toxic megacolon may prompt emergency surgery in CUC. The treatment of choice is abdominal colectomy and Brooke ileostomy with rectal preservation. This allows a subsequent IPAA. There is a risk of persistent sepsis and bleeding from the rectal stump which may require subsequent proctectomy. IPAA under emergency conditions can be safely performed in highly selected patients.[31]

Conclusion

Surgical management of CUC requires a complete understanding of the potential operative procedures. The decision with regard to when to operate requires a joint effort from the gastroenterologist and the surgeon. IPAA is the procedure of choice in most cases of CUC. Functional results and patient satisfaction with IPAA are generally good. Ileorectal anastomosis and proctocolectomy with Brooke ileostomy or Kock pouch also have their place in surgical management in select cases.

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21 & 22 - *St. Louis*: 10th Annual Frontiers in Endourology. Call 314/362-6893.

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26 thru 28 - *St. Louis*: Pacts/Pals Provider. Call 1-800-553-2712.

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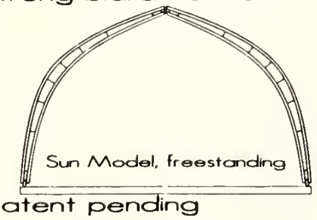

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Smoking-Cessation Guidelines

J. Regan Thomas, MD, Editor

Even a presidential candidate and a former surgeon general are debating the fine points of tobacco use. That scenario will continue to be played out over the next few months. Perhaps it points out that nothing is "black and white," especially in politics. There should be no debate however, that tobacco use provides a dramatic public health dilemma in our country. There should be no debate about the fact of enormous number of tobacco-related deaths and disabilities that our society must deal with each year. Tobacco-related illness kills approximately 420,000 Americans annually. Besides the estimated $50 billion related to the cost of medical care spent on diseases from smoking, another $47 billion annually is lost from productivity and forfeited earnings.

In recent months the Federal Agency for Health Care Policy and Research announced its guidelines for enhanced smoking cessation. Reportedly, these guidelines came after a two-year study by a panel of preventive medicine and public health experts.

"If there's one thing you can do to prevent the most illnesses in a given individual, it's to get the person to stop smoking which is far and away the most preventable cause of death and disability in the country."

– Richard D. Hurt, MD, Director of the Nicotine Dependence Center at the Mayo Clinic

These now public guidelines include suggestions aimed specifically at physicians. They not surprisingly encourage doctors to be more overt and proactive in urging their patients to stop smoking. Over 70% of smokers who visited a doctor in the past year say they wish to quit. According to a report in the *AMNews* however, only half say their doctor encouraged them to quit and even fewer report receiving advice on specific steps on quitting. New guidelines hope to make that physician interaction easier and more frequent.

New guidelines suggest that physicians identify patients who smoke by including smoking status as part of taking vital signs. Physicians should be prepared to direct those patients who ant to quit to specific smoking cessation plans as well as arrange follow up contacts. The guidelines also encourage the use of nicotine-replacement therapies. These treatments have been around for a long time, but not many doctors have used them aggressively for their patients.

Finally, the guidelines urge doctors to discuss smoking cessation in very specific and direct terms with their patients. Rather then mentioning smoking in passing, very clear and personal recommendations should be emphasized. Personal physicians can have a major impact on their patients' health and life-style decisions and we should not overlook this opportunity on their behalf.

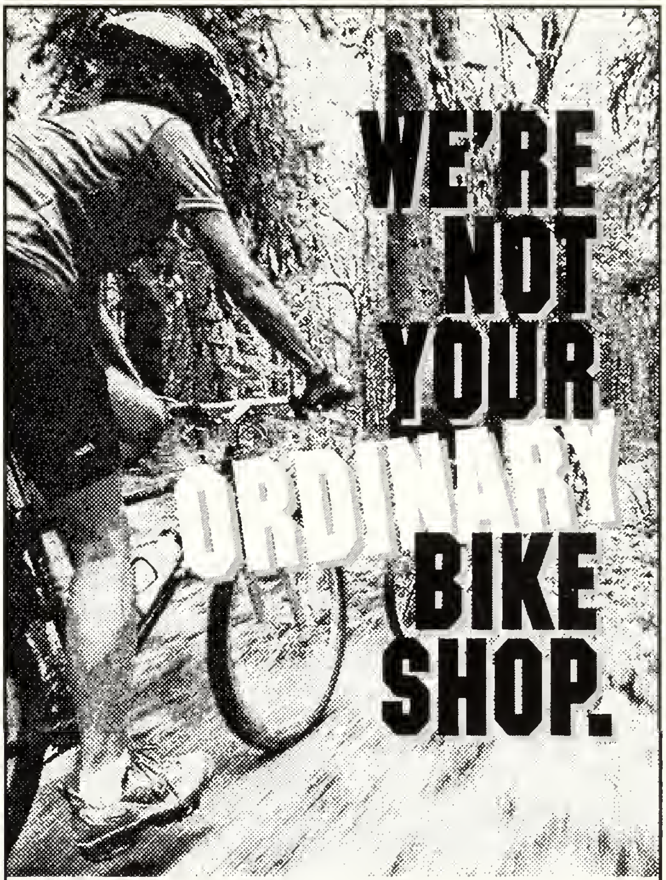
Political debates around big money issues like the tobacco industry will continue to go on. Within medical delivery systems decisions must be made and the

If 100,000 doctors could persuade 10% of patients who smoke to quit, the number of smokers in the U.S. would drop by two million.

level of commitment must be determined. For example, managed care programs must exhibit their willingness to finance smoking cessation services. Although on the surface it seems only logical that embracing these services would make sound financial sense (as well as good health policy) in terms of cancer reduction, cardiovascular improvement or pulmonary disease prevention. At this time though, only between 30% to 40% of managed care plans provide for these services. It seems that if "wellness" and prevention attitudes of managed care are really present, there should be 100% backing of these services.

The AMA plans to distribute about 200,000 pocket guide outlines of the national guidelines to primary care doctors this year. The goal is to reemphasize the awareness of the individual physician's role in this process. As quoted in *AMNews*, Richard D. Hurt, MD, director of the Nicotine Dependence Center at the Mayo Clinic, put it aptly, "If there's one thing you can do to prevent the most illnesses in a given individual, it's to get the person to stop smoking which is far and away the most preventable cause of death and disability in the country."

If 100,000 doctors could persuade 10% of patients who smoke to quit, the number of smokers in the U.S. would drop by 2 million. That would be a great start. MoMed



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The Physicians' Partner
Physicians as Employees

Daniel O'Sullivan, MD, MSMA President

"When I grow up I want to be a blue-collar doctor."

Imagine these words falling from the precious lips of your 8-year-old son as he looks at the wall containing all of your degrees, diplomas, licenses and the awards of a lifetime. Death and taxes, they say, are the only certain things. Change is another inevitability, and it is this change which those of us who are blessed with silver hair are attempting to adjust to amidst the evolution of health care delivery. It is difficult, however, for those of us who have practiced for years to fathom the enthusiasm of particularly younger physicians to accept the nine to five job as an employee of one of the many practice purchasers.

I still remember the excitement and the challenge of opening my first office. It was rent free, borrow a receptionist, and no patients. It was emergency call at five different hospitals and run, run all of the time. My first few hospitalized patients were seen three to six times a day because I didn't have anything else to do. When I could finally afford my own receptionist, she would grab patients walking by the door, bring them in the waiting room and call me. Because of ambition, hard work and the kindness of many older referring physicians I, as a young surgeon, was rewarded with opportunity and eventually by 30 years of very satisfying private practice.

For these reasons I find it confusing that a young man would suffer the outrageous slings and arrows of medical school to become an employee. Professionalism has always been a complimentary term describing physicians, attorneys, dentists and a few others. The dedication and caring for patients which we like to associate with the art form of medicine distinguishes our vocation from very worthy occupations such as business and sales and marketing and the insurance industries. Why, I wonder, would an individual surrender these rewards for a position of dependency.

The average indebtedness of the medical school graduate in 1996 hovers around $100,000. The cost of establishing a private office including medical liability insurance, compliance with OSHA standards and managed care criteria make the new solo practitioner a rarity and somewhat of a freak of medicine. Many practitioners still are interested in association with young physicians. But in this day and age it seems this is also a very expensive proposition. So, the easy answer is to function as employees.

The things that we as physicians are demanding of managed care and medical practice in general are autonomy of medical-making decisions, significant voice in utilization review and credentialing procedures, and a strong voice in policy making. There is no room for such demands or negotiations for the employed physician. I was once told by a managed care medical director that if a particular hospital wanted the patients of their group, they would have a to provide full-time intensive care coverage since the providers in that group would be at their desks and unavailable for emergency care.

None of this implies that the intelligence of the individual physician is less or that the quality of their service for the benefit of the patient is less, however, it appears that the concept of the employed physician portends a dismal future for the concept of the medical profession. When I grow up I want to be a blue-collar doctor.

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June 25, 1996 at The Drake Hotel – AMA President Lonnie Bristow, MD, with the assistance of John "Jock" Mitchell, MD, installed Sandra Mitchell as the AMA Alliance President for 1996-97.

Sandy is the fourth Missouri Alliance member to become AMA Alliance President. Two Past AMAA Presidents include Mary Kay McPhee of Kansas City and Betty Sutter of St. Louis, pictured left and right of Sandy Mitchell.

Sandra Mitchell from Kansas City Installed President of the AMA Alliance

AMA Alliance President Sandra Mitchell targets violence as year's focus. "Since last October's launch of the national SAVE Program to Stop America's Violence Everywhere, the AMA Alliance has been at the forefront of the battle to end violence," said Sandra Mitchell, 1996-97 president of the American Medical Association Alliance in her inaugural address on June 25, 1996.

Defining her plans and goals for her year as president of the national volunteer organization of physicians' spouses, the Kansas City resident urged Alliance organizations throughout the country to build on efforts to end violence. "No one has the right to abuse or harm another person, such abuse will not be tolerated by society, by the law, and most certainly not by medicine," said Mitchell.

This year, the Alliance has partnered with the AMA in an unprecedented effort to unite the medical community in its fight against violence. This effort has culminated through the creation of the SAVE-A-Shelter program, a campaign designed to urge physicians and physicians' spouses across the nation to adopt an abuse shelter, transition home, rape crisis center, or safe haven serving victims and their children in their community.

Outside the Alliance, Mitchell has been active with the Auxiliaries of Trinity Lutheran and the former St. Mary's Hospitals. She has also worked with the local chapter of the Missouri Hospital Association training members on "How to Be a Good Auxilian."

Married to urologist John D. Mitchell, MD, Sandra was 1987-88 president of the Missouri State Medical Association Alliance.

As last year's president-elect, Mitchell was instrumental in promoting the SAVE Program to state and county Alliances through workshops, keynote addresses, and legislative updates. MoMed

Radiology Quiz #6

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

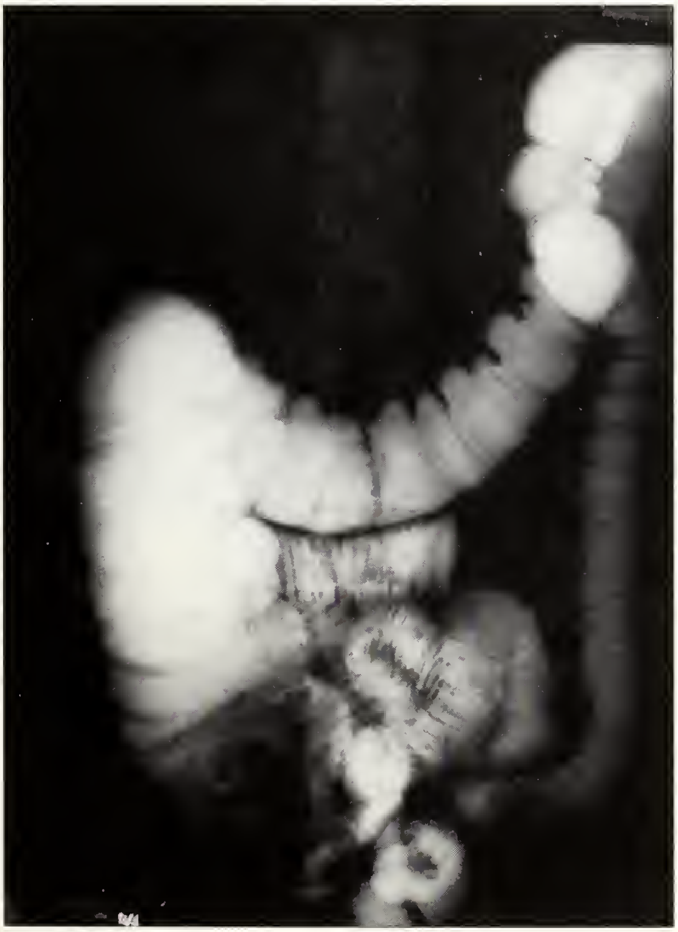


Figure 1

A 55-year-old woman presented with lower abdominal pain. You are shown a film from a barium enema examination (fig. 1).

What is the diagnosis?

- **a. Sigmoid diverticulitis**
- **b. Periappendiceal abscess**
- **c. Granulomatous ileitis**
- **d. Ileocolic intussusception**

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

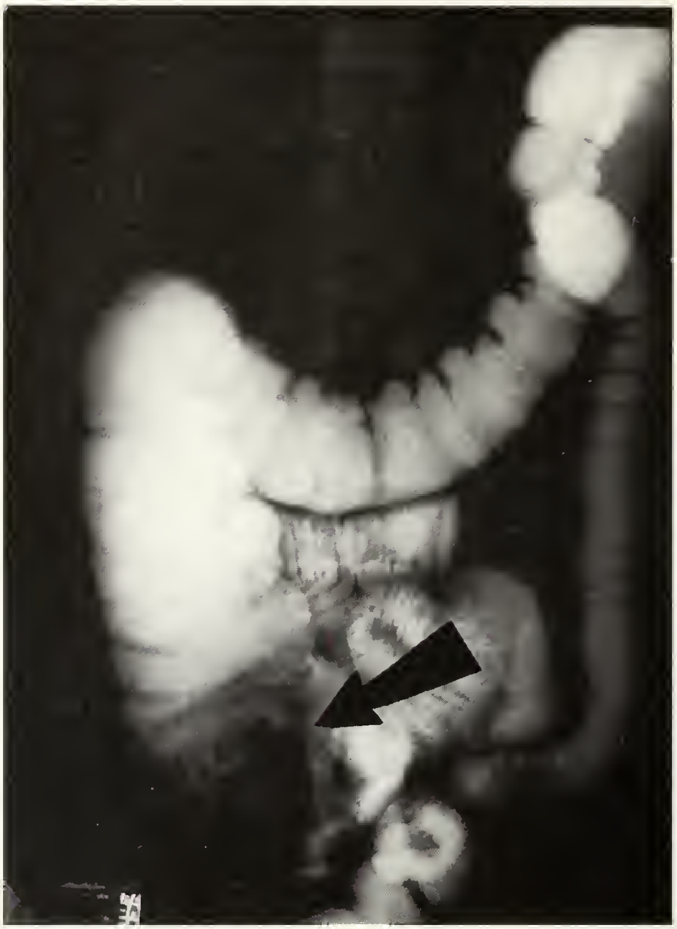
ANSWER: b. Periappendiceal abscess

The A.P. film of the barium filled colon shows a 6 cm extrinsic mass indenting the inferior medial aspect of the cecum (arrow). The appendix is not filled, although the patient denies previous abdominal surgery. The remainder of the colon and the terminal ileum appear unremarkable. At surgery, the appendix was acutely inflamed and perforated, with a walled off collection of pus.

In the patient presenting with lower abdominal pain, the clinical diagnosis is often unclear. Imaging studies may help to reduce the rate of removal of normal appendices. Ultrasound with graded compression may help if a thick walled, non-compressible tubular structure is seen around the cecum. C.T. scanning may be helpful by showing abscess in cases of ruptured appendix, or infiltration of adjacent fat suggesting inflammation with or without abscess. C.T. or ultrasound also can be helpful by ruling in or out other causes of lower abdominal pain including diverticular abscess or cystic ovarian disease. Barium enema examination may also help by ruling in or out appendicitis. Filling of the appendix with barium effectively rules out appendicitis. Non-filling of the appendix may be normal or abnormal. However, non-filling of the appendix with an extrinsic mass involving the cecum in the clinical setting of right loser quadrant inflammation suggests appendicitis until proven otherwise.

Option A, sigmoid diverticulitis is incorrect since a definite mass or diverticulosis involving the sigmoid colon is not seen. However, diverticulitis may occasionally involve the right colon and mimic appendicitis.

Option B, granulomatous ileitis or Crohn's disease would be unlikely to involve the cecum without involvement of the terminal ileum. However, Crohn's disease may involve any part of the gastrointestinal tract.



Repeat Figure 1

Option C, ileocolic intussusception, would not present as an extrinsic cecal mass with patent ileum. Intussusception presents as a "coiled spring" intraluminal filling defect due to prolapse of proximal bowel (intussusceptum) into distal bowel (intussusceptiens). This disorder occurs more commonly in children, and may sometimes be reduced by a lower pressure barium or water soluble contrast enema.

References

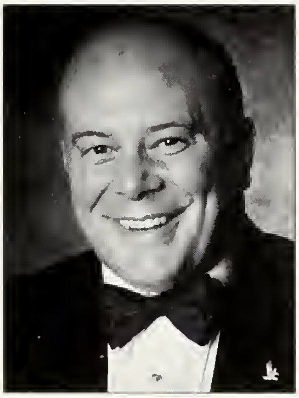
1. Brown, JJ. Acute appendicitis, the radiologist's role. *Radiology* 1991;180:13.

2. El Ferzli, G et al. Barium enema in diagnosis of acute appendicitis. *Surg Gynecol Obstet* 1990;171:40-42.

Membership Notes

Thomas W. Carroll, MD

Thomas W. Carroll, MD, of Lamar, Missouri, has been named the Missouri Family Physician of the Year by the Missouri Academy of Family Physicians. Dr. Carroll was chosen because he is a "living example of the Hippocratic Oath in its entirety who truly lives up to his oath while trying to make our world a better place, both inside and outside his profession," said Bruce Preston, MD, MAFP Director. Dr. Carroll opened a private practice in Lamar in 1955, where he has delivered medical care for over 40 years.



Ira J. Kodner, MD

Ira J. Kodner, MD, Director of the Section of Colon and Rectal Surgery, and Professor of Surgery at Washington University Medical Center, has been elected President-elect of the American Society of Colon and Rectal Surgeons (ASCRS) for 1996-97. Dr. Kodner as served on the ASCRS Executive Council for five years, and as Secretary for 1992-1996. He has chaired the Program Committee, and served on the Current and Future Issues, and Advisory to University Colorectal Surgeons committees. He is past president of the American Board of Colon and Rectal Surgery and has served on the Board of Directors of the American Board of Surgery. Currently he is a Senior Examiner for both boards.

M. Scott Beall Jr., MD, Kansas City; **Richard Valuck Jr., MD,** Hannibal; **Alan DuMontier, MD,** Creve Coeur; **Jerry Meyer, MD,** Concordia; **Carl Myers, MD,** Platte City; **L. Kenneth Pottenger, MD,** Joplin, and **Stephen Smith, MD,** St. Louis, have been selected to serve on the MU Medical Alumni Organization's Board of Governors. The board governs the alumni organization, monitors issues at the Health Sciences Center and advises the school's administration by offering proposals and serving on committees.

Andrew Haber, a University of Missouri-Columbia medical student, received an honorable mention for poetry submitted in the 14th annual William Carlos William Poetry Competition. His poetry may appear later this year in *JAMA*.

Harold Williamson Jr., MD, Professor and Associate Chair of Family and Community Medicine at the University of Missouri-Columbia, has been elected president of the Missouri Rural Health Association.

Richard H. Gelberman, MD, Fred C. Reynolds Professor of Orthopaedic Surgery at Washington University, received a four-year grant from the National Institute of Arthritis and Musculoskeletal and Skin Diseases for a research project titled "Flexor Tendon Healing."

David J. States, MD, PhD, Associate Professor of Genetics and Biochemistry and Molecular Biophysics and Associate Professor and Director of the Institute for Biomedical Computing and Biomedical Engineering at Washington University, received a grant from the National Center for Research Resources for a project titled "Intelligent Systems for Molecular Biology Conference 96."

The University of Missouri-Columbia has a new scholarship established by a late Jackson couple, **Lee and Katherine Cochran**. Lee Cochran was a former executive secretary of the Cape Girardeau County Area Medical Society and also southeast Missouri coordinator for the Missouri Regional Program, a federally funded program that benefited heart, stroke and cancer patients through research and programs. The scholarship will be awarded to one incoming first-year medical student on a renewable basis. To be eligible the southeast Missouri medical students must intend to become a primary-care physician.

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine****, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

New Members

Audrain

Shahid Waheed, MD - IM
626 Summit St., Mexico, MO 65265
Am Univ of the Caribbean; 1984

Buchanan

John P. Olson, MD - NS
3109 Frederick Ave.
St. Joseph, MO 64508
University of Kansas; 1990

Clay-Platte

Eve M. Krahn, MD - PD
2700 Clay Edwards Dr. #350
Kansas City, MO 64116
University of Missouri-KC; 1988

Cole

John C. Lucio, DO - AN
P. O. Box 454, 1015 Madison
Jefferson City, MO 65102
Univ Coll of Osteo Med, MI; 1988

Randall E. Mitchem, DO - IM
P.O. Box 1128
Jefferson City, MO 65102
Univ Health Sci Ctr, KC; 1987

Grand River

Syed F. Jafri, MD - IM
1 Cross St., Hamilton Med. Clinic
Hamilton, MO 64644
Dow Med Col Karachi, Pakistan; 1990

Greene

Thomas Corsolini, MD - PMR
3800 S. National #460
Springfield, MO 65807
University of Illinois; 1985

Dorsey W. Dysart Jr., MD - N
3525 S. National Ave Ste 202
Springfield, MO 65807
Tulane University; 1967

Barbara A. Fedor, MD - IM
1965 S. Fremont Ste 3500
Springfield, MO 65804
University of Texas, Houston; 1984

John M. Fry, DO - FP
626 E. Battlefield
Springfield, MO 65807
KCOM Kirksville; 1965

Kathleen Gafarian, MD - DR
1235 E. Cherokee
Springfield, MO 65804
Wayne State University; 1988

Michael B. Grillot, MD - ORS
1001 E. Primrose
Springfield, MO 65807
University of Kansas; 1988

Lawrence Koppers, MD - END
1443 N. Robberson 6th Fl
Springfield, MO 65802
University of Kansas; 1966

Peter J. Molberg, MD - FP
1423 N. Jefferson B100
Springfield, MO 65802
Stanford University; 1975

Stephen J. Neu, MD - AN
1350 Woodhurst
Springfield, MO 65807
St. Louis University; 1984

John B. Steinberg, MD - GS
1001 E. Primrose
Springfield, MO 65807
University of Utah; 1985

Mark R. Ward, MD - FP
1660 E. Kearney
Springfield, MO 65803
University of Kansas; 1978

Robert B. Wyrsch, MD - HS
2115 S. Fremont Ste 1000
Springfield, MO 65804
Vanderbilt University; 1990

Kenneth R. Young, MD - AN
1000 E. Primrose Ste 520
Springfield, MO 65807
University of Missouri-Columbia; 1981

Jasper-Newton Metropolitan

Brett E. Boice, DO - OBG
2700 McClelland Blvd Ste 304
Joplin, MO 64804
Oklahoma State University; 1987

Tracy L. Coe, MD - ON
2817 McClelland Ste 353
Joplin, MO 64804
UTHSC, San Antonio; 1989

Rex K. Crumpacker, MD - AN
3333 McIntosh Circle
Joplin, MO 64804
University of Kansas; 1990

Yoganand Hiremath, MD - CDS
2817 McClelland Blvd #224
Joplin, MO 64804
University of Missouri-KC; 1989

Thomas Reinsvold, MD - CDS
1111 McIntosh Circle Ste D
Joplin, MO 64804
Univ of California, Los Angeles; 1986

Henry A. Stiene, MD - IM
1111 McIntosh Cir., Joplin, MO 64804
University of Cincinnati; 1986

John Stucka Jr., DO - R
P. O. Box 2399, Joplin, MO 64803
Philadelphia Col of Osto Med; 1975

MSMA

David T. Walden, MD - GE
One Barnes Hosp Plaza Div GE
St. Louis, MO 63110
Univ of Texas, Galveston; 1987

Metro Med of Greater K.C.

Karen M. Gehrs, MD - OPH
4321 Washington Ste 5000
Kansas City, MO 64111
University of Missouri-Columbia; 1987

Julie R. Heise, MD - AN
2525 Glenn Hendren Dr.
Liberty, MO 64068
University of Missouri-KC; 1991

Dwayne E. Jones, MD - AN
8800 Blue Ridge Blvd. #200
Kansas City, MO 64138
Meharry Med School Nashville; 1987

Larry D. Ray, MD - P
14085 Copper Creek Dr.
Olathe, KS 66062
University of Kansas; 1987

Mineral Area

Lemuel T. Barrido, MD - IM
212 E. Jefferson, Potosi, MO 63648
Iloilo Doctors' Coll of Med,
Phillipines; 1990

North Central

Carl D. Brown, DO - N
902 E. LaHarpe #116
Kirksville, MO 63501
Chicago Coll of Osteo Med; 1979

St. Louis Metropolitan

James S. Burke Jr., MD - ORS
3009 N. Ballas Rd. #105
St. Louis, MO 63131
University of Missouri-KC; 1989

Rosemary Cannistraro, MD - IM
777 S. New Ballas Rd.
St. Louis, MO 63141
St. Louis Univ; 1992

David W. Chien, MD - AN
10010 Kennerly Rd.
St. Louis, MO 63141
University of Missouri-Columbia; 1991

Steven T. Fogel, MD - AN
14901 Conway Glen Ct.
Chesterfield, MO 63017
University of Missouri-Columbia; 1976

Mary M. Kiehl, MD - IM
1 Barnes Hosp Plaza #16422
St. Louis, MO 63110
University of California; 1990

Timothy P. Rearden, MD - IM
11125 Dunn Rd, Ste 308
St. Louis, MO 63136
University of Missouri-Columbia; 1985

Robert W. Tolan Jr., MD - PD
4503 McPherson #302
St. Louis, MO 63108
Washington University; 1987

Residents

Dale E. Korn, MD - U
Laura M. Alba, MD - IM
Haleh G. Bassiri, MD - IM
Tim Stout, MD - IM
Christopher Hirose, MD - GS
Daniel L. Kitchens, MD - NS

Students

St. Louis University
Matthew Henry

University of Missouri-Columbia
Maryam M. Nouri

University of Missouri-K. C.
Umraan S. Ahmad
Sai H. Chavala
Shiraz Daud
Michael J. Giocondo
Joel McReynolds
David E. Mohart
Christopher R. Montgomery
Saad A. Naseer
Charles E. Woodall, III

In Memoriam

Alvin L. Lowe, MD, 78, Sedalia, Missouri, died June 8, 1996. Dr. Lowe received his medical degree at the University of Oklahoma in 1951. He practiced medicine in Sedalia and Cole Camp area from 1951 to 1985 and worked for the Indian Health Service from 1990 to 1994. Dr. Lowe was a veteran of the Army Air Corps. Dr. Lowe was a member of the American Academy of Family Physicians.

Franklin C. Werner, MD, 76, Liberty, Missouri, died May 24, 1996. Dr. Werner received his medical degree at the University of Pennsylvania in 1944. He finished his internship and residency at the Kansas City General Hospital. Dr. Werner was formerly the Chief of Surgery and President of the Medical Staff at the North Kansas City Memorial Hospital. He had practiced at the hospital since it's inception. Dr. Werner was a member of the American College of Surgeons and The Southwestern Surgical Congress.

Ellsworth A. Westrup, MD, 84, Webster Groves, Missouri, died June 14, 1996. Dr. Westrup received his medical degree at Washington University in 1937. He was an intern at Deaconess from 1937 to 1939 and then went into private practice with his father in Webster Groves. Dr. Westrup practiced as a family physician for 50 years. He was on the staff of Deaconess Hospital for 50 years, and also on staff at St. Mary's Hospital in Richmond Heights for more than 20 years and with St. Joseph Hospital in Kirkwood through the 1960s. He retired in 1987 and moved to Eureka.

Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

Gary Beauchamp, Kansas City
Irene E. Bettinger, Kansas City
John J. Bonacorsi, Bridgeton
Saul Boyarsky, St. Louis
Sei Y. Choi, St. Louis
Elizabeth W. Diehl, St. Louis
Jack Edminsten, Nevada
Josiah O. Ekunno, St. Louis
Kent A. Huston, Kansas City
Loretta S. Loftus, Kansas City
Ernest Lorenc, Springfield
Thomas W. Lynch, Springfield
Marvin L. Mack, Columbia
Lyell M. Magruder, Nevada
Andrew McCanse, Kansas City
Carl A. Petit, Osage Beach
Lowell K. Pottenger, Joplin
Lisa B. Ring, St. Louis
Howard H. Roberts, Joplin
David M. Schlossman, Columbia
Thomas A. Schneider, St. Charles
Donald Thibeault, Kansas City
Thomas P. Wescott, Holden
Robert J. Williams, St. Joseph
Mark W. Wurster, Kansas City

AMA Resident Physician Section Meets in Chicago

Howard D. Pomeranz, MD, PhD, Chair, MSMA Resident Physician Section
Vice-Councilor, MSMA Council

The twentieth annual session of the AMA Resident Physician Section (RPS) Assembly took place June 21-22, 1996 in Chicago. Representing the MSMA Resident Physician Section were **Howard Pomeranz, MD, Mary Vest-Mason, MD, Robert Phillips, MD** and **Robert Swanson, MD**. The annual Assembly meeting was devoted to several items of business including the discussion of 37 resolutions and several RPS Governing Council reports as well as the annual election of RPS Governing Council officers. The following is a brief synopsis of resolutions and reports of interest to resident physicians:

1) The RPS adopted a resolution asking the AMA to support federal legislation requiring HIV testing of all pregnant women at the earliest prenatal visit, except when there is specific signed refusal, in order to allow women the opportunity to improve their own health and that of their child.

2) A resolution was adopted asking the RPS to create an ad hoc committee to be responsible for the development and facilitation of on-line communications for the RPS and to study the advantages and disadvantages of an RPS listserv.

3) The RPS adopted a resolution asking the AMA to adopt the following language regarding the USIA J-1 Visa: "that the USIA J-1 Visa policy for international medical graduates should be the same as for non-physician applicants."

4) Two resolutions regarding the subject of graduate medical education were referred to the RPS Governing Council.

One resolution asked the AMA to study and make specific recommendations regarding resident contracts which would encompass the entire duration of the residency program. These contracts should include, but not be limited to, provisions addressing changes in residency benefits in the event of (1) closure, downsizing, or merger of the residency program and (2) closure, sale, or merger of the teaching hospital.

The second resolution asked the AMA to strongly encourage the appropriate regulatory bodies to require residency programs to offer placement of their resident physicians in comparable positions before disbanding a training program.

These resolutions were stimulated by the increasing frequency of threatened closure of residency programs around the country, specifically in Los Angeles and New York City. The RPS Governing Council will study these issues and report back to the RPS Assembly at the interim meeting in December 1996.

5) The RPS sent a resolution to the AMA House of Delegates asking for support of the option of limited educational licenses in all states for the purpose of residency training and that the AMA support reduced licensure fees for resident physicians when full medical licensure is required by a state for residency training.

A training session took place on June 21st entitled "Educating Your Colleagues about Domestic Violence." Robert E. McAfee, MD, Immediate Past President of the AMA gave a well received presentation. Dr. McAfee has been instrumental in leading the AMA campaign on education of physicians about domestic violence. Training materials were distributed to participants on incorporating questions about domestic violence into the taking of histories from patients. In addition, resource materials for appropriate referral of patients were made available.

The AMA plans to create slide and video presentations on domestic violence which can be used to educate our colleagues and ourselves in the form of grand rounds or educational seminars. These materials will be available in fall 1996.

The AMA has already produced diagnostic and treatment guidelines on topics such as child and elder abuse and neglect, child sexual abuse, mental health effects of family violence, and sexual assault. These pamphlets as well as additional information are available from the AMA by calling 1-800-AMA-3211.

Robert Phillips, MD, a family practice resident from Columbia, Missouri and former chairperson of the AMA Medical Student Section Governing Council, was elected to the resident seat on the AMA Council on Medical Education. He was supported by the MSMA, the Missouri Academy of Family Physicians, and American Academy of Family Physicians and the AMA Resident Section.

Missouri resident physicians in attendance at the AMA Resident Physician Section annual meeting in Chicago June 21-22, included (left to right): Robert Phillips, MD, Columbia, Mary Vest-Mason, MD, St. Louis, and Howard Pomeranz, MD, St. Louis. Robert Swanson, MD, Ballwin, also attended.

Any resident physician or fellow in Missouri is encouraged to become active in the MSMA Resident Physician Section. For further information regarding the section or membership in the MSMA, call 573-636-5151.

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Health on the Net

Michael W. Vannier, MD, Chair, MSMA Physicians' Internet Advisory Committee

Business Week recently announced, "The Software Revolution - the Web Changes Everything," and *Byte's* cover says, "Toss Your TV - How the Internet Will Replace Broadcasting," We are in the midst of a revolution in computer and telecommunications technology that will profoundly affect our lives - personally and professionally.

The need to quickly process and transmit complex information is now the driving force in computer and telecommunication hardware and software developments. A featured newspaper article described how physicians and patients benefit from using the Internet and its 10,000 health-related medical sites to practice better medicine, to investigate various diseases, drugs, and treatments, and to communicate with colleagues worldwide.

MoMed Net is now available at the Missouri State Medical Association, so members can enjoy these benefits. MSMA recognizes the needs of its physician members and to Missourians: to enhance the doctor-patient relationship; to promote better health and health care; and to support the discovery and dissemination of knowledge of human health and disease. These goals are taken directly from the MSMA Mission Statement, and cognizant of these, MSMA partnered with Sprint Healthcare Systems to provide convenient electronic access to medical information for its members and the citizens of Missouri.

MoMed Net is MSMA's answer to physicians and patients who want a "one-stop-shop" for medical information. **MoMed Net** is an Internet service program; it provides Association members full, unlimited access to the Internet. No long distance telephone fees, no additional charges to rack up after you've been online for more than some allotted time, no limits on where or how far you can go on the Internet. And with **MoMed Net**, you have global e-mail capabilities, too.

The only requirement is that you be a member in good standing with MSMA and have the computer with sufficient resources to be electronically connected and run web browsers. The street price for a fully configured desktop computer is less than $2,000 today, and a minimal system costs about $800.

Information-Fast and Accessible

It's been reported that 70% of a physician's time is spent processing information, either collecting it or reviewing it. MSMA's Physicians' Advisory Committee designed the Home Page to be all-encompassing and easy to use. Located on the World Wide Web at **http://www.msma.org,** the Home Page was designed to get essential information to physicians and the public quickly. When you connect to MSMA's Page, (and with **MoMed Net**, you can connect at up to a speed of 28.8 Kbps), you find three areas inviting you to explore, one for members, one for the public, and one describing what MSMA is all about.

Confidentiality and security played a dominant role in the design of the Home Page; you'll need your user identification and a password to enter the member-only MSMA file areas. Once you're in, you have access to the MSMA news and information that provides an edge in practicing your profession. You want details of how the Senate voted on the Patient Fairness Act? Click on "Governmental Affairs." You're going to be in St. Louis for four days and are looking for a CME opportunity? Point to "Continuing Education" to get the details. How about information on managed care and its effect on physicians? Click on "Health Care Finance" and get the latest news from around the state.

Other areas include "MSMA Publications," "Missouri State Medical Services," "Minutes and Reports," "Annual Convention," "Membership," "Alliance," "Meetings," and "Medical Specialty Groups."

Continued on page 333

Get Connected to the Information Superhighway!

Missouri State Medical Association's

MoMed Net

Providing members with full, unlimited Internet access!

The Missouri State Medical Association and Sprint Healthcare Systems have created **MoMed Net**, an Internet Connection Program providing MSMA members with full, unlimited Internet access. It works like this:

Unlimited Access

MSMA members may subscribe to full and ***UNLIMITED*** Internet access for $17.50 monthly. You will be billed monthly automatically on a Visa or MasterCard credit card account. You can surf the Internet or the World Wide Web as long as you wish for one low price!

Software Provided

MSMA will provide you with Netscape Navigator, the premier web browser. Once installed, Netscape automatically dials a local telephone number (no long distance charges!) and connects you to the MSMA's World Wide Web Home Page at http://www.msma.org. Our Home Page is your 'one-stop-shop' for medical information! From there, you can instantly be connected to MSMA, other medical sites or use search tools to take you anywhere on the Internet.

Global E-Mail

Through **MoMed Net**, you will have global e-mail service, (one e-mail address per account), connecting you to thousands of Association members and physicians all over the world!

Password Protection

Security and password protection keeps information at the MSMA Web site preserved for members only.

Fast Connections

You can access **MoMed Net** with modems up to 28.8 Kbps, so you get the information you need fast!

Training Seminars and Technical Assistance

MSMA is developing Internet seminars to teach physicians the easiest way to surf the Information SuperHighway. Need technical assistance? Sprint will be providing toll-free technical support, 24-hours-a-day, seven-days-a-week.

Computer Equipment Requirements

Requirements for connection to **MoMed Net**: a Windows operating system, a 14.4 Modem or higher, a 386 or higher, and at least 8 megs of RAM.

Program Eligibility

MoMed Net is available in these four locations: St. Louis, Kansas City, Springfield, and Jefferson City. Future expansion of MoMed Net includes Columbia, St. Joseph, Joplin, Cape Girardeau, and other areas in Missouri.

How do I sign up?

Complete the **MoMed Net** application on the next page and fax it to MSMA at 573-636-8552. MSMA will verify that you are a member in good standing. You will then be assigned an e-mail address, user identification, and receive your program installation instructions.

Questions? Contact the MSMA at 573-636-5151.

Visit the Missouri State Medical Association's Home Page

http://www.msma.org

MISSOURI STATE MEDICAL ASSOCIATION

Internet Service Application-For Members Only

Please complete and mail or fax to:
MSMA, 113 Madison • P.O. Box 1028 • Jefferson City, 65102
Tel: 573-636-5151 • Fax: 573-636-8552

Name ______________________________ Date of Birth ______________

Billing Address ______________________________

City/State/Zip ______________________________

Tele# ______________________________ Fax# ______________

Billing Preference* (Check and complete one option)

○ MasterCard ○ Visa Card# ______________________________ Exp. Date ______________

*You will be billed monthly automatically. Signature ______________________________

IMPORTANT: Please fill in a 3-8 character Password, to be used during Phase 1, containing at least two letters and one numeral: ☐☐☐☐☐☐☐☐

SYSTEM REQUIREMENTS

To ensure the highest quality service, your hardware requirements for MSMA Internet Service need to be:

- ✓ Operating Systems
  - Windows 95
  - Windows 3.1
  - Windows NT
- ✓ 14.4 Modem or higher
- ✓ 386 or higher
- ✓ 8 megs of RAM or higher

If you do not meet these minimum requirements, we request that you upgrade to ensure proper Internet connectivity and operations.

TYPE OF OPERATING SYSTEM

_____ Windows 3.1 _____ Windows 95

_____ Windows NT

_____ Other: ______________________________

Modem Brand ______________________ Speed __________

TYPE OF COMPUTER

_____ 386 _____ Pentium

_____ 486 _____ Other

Please check the MSMA information files you would like to see on-line.

- ○ *Progress Notes*
- ○ *Missouri Medicine*
- ○ Legislative
- ○ Health Care Finance
- ○ Continuing medical education listings
- ○ On-line continuing medical education
- ○ Medical-legal
- ○ Alliance news
- ○ Membership
- ○ Council and committee reports
- ○ County/metropolitan society news
- ○ Medical specialty news
- ○ Other ______________________________
- ○ Other ______________________________

FOR MSMA OFFICE USE ONLY

○ Active Member ○ Resident ○ Student ○ Affiliate ○ Military

Your assigned ID is ______________________________

Your assigned E-Mail address is ______________________________ @2sprint.net

NOTE: *Users must use ID and Password to enter the confidential MSMA section.*

Sprint Healthcare Systems, Inc.

Sprint.

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One-Stop-Shop

The very last hot button on MSMA's page is "Other Medical Links." We wanted to provide our members with an ever-growing list of medical links, that is, other medical web sites, pertinent to our members, so they wouldn't have to look up those sites on their own. We've got links to the *National Institutes of Health, the National Library of Medicine, the American Medical Association, OncoLink, Centers for Disease Control,* and more. For the general public, MoMed Net offers medical information on breast cancer, immunizations, managed care, and other timely, popular medical topics.

MSMA recognizes that electronic connectivity can benefit health care delivery. If you're interested in what the Internet has to offer medicine, **MoMed Net** is the way to get you there.

Internet Glossary

BANDWIDTH - Capacity for transmitting digital data; expressed in bits per second, as in 64kbps (64,000bps) or 1.54 Mbps (1,540,000 bps).

BROWSER - A software program used to communicate with servers, retrieve and read web documents, and follow hyperlinks to other documents. Internet service providers usually give this to you and browsers can be downloaded for free on the Internet.

DIALUP CONNECTION - Dial into an Internet service provider using a modem and telephone line to access the Internet.

DOMAIN - The name of your web site and followed by an extension designating the type of site (com=commercial, edu=education, gov=government, org=organization).

E-Mail - Electronic mail (also called email or just mail) messages sent by way of the Internet to a particular person.

FAQ - "frequently asked questions," a common acronym on the Internet, i.e. medical site might have a heading "FAQs on Cancer."

FTP (File-Transfer Protocol) - A method of transferring one or more files from one computer to another on a network or phone line. By using a protocol sending and receiving programs can check that the information has been received correctly.

FIREWALL - A system has a firewall around it if it lets only certain kind of messages in and out from the rest of the Internet.

GOPHER - A relatively new menu driven search feature. Gopher uses keywords to "tunnel" through the millions of files available on the Internet and locate files associated with the specified keywords. Once located, Gophers can retrieve files for you.

HOME PAGE - The first page of a web site.

HOT JAVA - The new browser from Sun Microsystems that many are touting as the next generation browser. It allows you to download and run miniature applications that are written in a language called Java. It could make possible low-cost computers for accessing the Internet.

HTML - HyperText Markup Language. Actually a subset of **SGML** (Standard Generalized Markup Language), HTML is the language in which web pages are written. It uses functional tags to describe pieces of text (headers, bullet lists, footers, etc.). Individual browsers display HTML text and graphics differently so the appearance of web pages may vary according to which browser you use.

HTTP (HyperText Transport Protocol) - The protocol for connecting and transporting hypermedia web documents across the Internet. HTTP supports the embedding of hyperlinks in the documents.

HYPERLINK (or link) - A word or image in a web document that when selected by clicking on it with your computer's mouse connects you with a new site, page, or even a different location on the same page.

ICON - A picture intended to represent something such as a program or a choice of action or object.

INTERNET PROVIDER - Company that provides a gateway or access to the Internet. It offers customers an electronic connection (direct or through a modem) to the Internet, as well as software and services.

IRC (Internet Relay Chat) - Interactive, real-time discussions between Internauts. Users log onto special Net Computers and join discussions already in progress.

MODEM (MOdulator/DEModulator) - Converts digital data to analog signals and vice versa; used to transmit digital data over telephone lines.

NETSCAPE NAVIGATOR - Currently the most popular web browser.

PAGE (or web Page) - A page in a single web document. Does not fit on your monitor's screen or on an 8.5"x11" sheet of paper. A web page can be very long, requiring you to scroll through it and may in fact take several pages when printed on paper.

SEARCH ENGINE - Search engines are software programs employing a variety of strategies to locate web sites. Yahoo is the most well-known search engine.

SERVER - The computer and software that manages the data at a web site. It responds to requests from browsers, keeps track of their activity, and reports to the owner.

SITE - A group of related interlinked pages located on a specific server and with its own address or URL.

TELNET - A standard that allows you to logon and operate computers at institutions around the world. This operation is helpful when searching databases, library catalogs, etc.

URL - Universal Resource Locator. This is the computer address of a web site or individual page.

USENET NEWSGROUPS - More than 7,000 topic-oriented message bases that can be posted and read.

WORLD WIDE WEB - The WWW consists of the specific documents conforming to specific Web standards, such as HTTP and HTML. These documents reside in computers loaded with special document management software called servers.

The Wired Physician:

Current Clinical Information on the Internet

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Mary Ann McFarland, MALS, Assistant Director for Access Services
Saint Louis University Health Sciences Center Library

The Internet and associated World Wide Web are electronic technologies that can help physicians identify needed clinical information quickly and can put physicians in ready contact with other specialists for communication and consultation. This article outlines the kinds of resources available on the Internet and methods for connecting your personal computer to the "information superhighway." Selected Internet sites and a short bibliography of books and articles relating to the Internet are included.

We are living in an increasingly electronic age, but sometimes we are not entirely clear on how to take advantage of newer electronic technologies, how to use them to make us more effective in our lives at work and at home. You probably subscribe to several journals in your area of practice and struggle to keep up with them. You probably also own several key textbooks and pharmaceutical works. But what do you do when you need to find out about something beyond the scope of the printed journals and books you have at hand? This is an excellent example of an area where the electronic technologies currently available, particularly the Internet and its associated World Wide Web capability, can have a dramatic impact.

More and more, physicians turn to their personal computers in situations when they need to find out more about a subject, particularly when they do not have the resources of a large medical library readily available. Although only a few of the many choices of Internet resources and databases can be outlined in a brief paper like this one, these examples can acquaint you with the general kinds of materials available to you, and with a little exploration and perhaps the advice of your local medical librarian, you will be able to find what you need quickly and efficiently.

Definitions

The Internet may be defined simply as a global network of computer networks. In the 1960s the Department of Defense realized the impact of computers on scientific and military research; it funded an experimental network called ARPANET (originally planned to insure alternative routing for military communications in the event of war) which allowed research sites to exchange information through high speed cables. Virtually any university in the United States with a contract for research for the U.S. government could be connected. During the eighties, scholars and researchers needed access to the capabilities of larger computers as well as to each other's research. The National Science Foundation established a number of supercomputer centers and funded a backbone connecting these centers to regional networks. This is the Internet we know today; it offers a doorway to an incredible array and volume of information, but weeding through the mass of information can be discouraging!

The basic text-based Internet capabilities or "protocols" are electronic mail (e-mail), telnet, gopher, and file transfer protocol (FTP). E-mail programs let you send and receive messages electronically. Telnet allows you

Table 1. Discussion Groups (Listservs)

Name	*Address*	*Notes*
ADA-LAW	listserv@vm1.nodak.edu	Legal issues of Americans with Disabilities
ALLERGY	listserv@tamvm.1.tamu.edu	Focuses on allergy
BIFIDA-L	listserv@mercury.dsu.edu	Spina bifida list
BMT-DR	BMT-Dr-Request@sjuvm.st.johns.edu	Focus is physicians involved with bone marrow transplantation
DIABETES-NEWS	listserv@netcom.com	Weekly newsletter about diabetes
DOWN-SYN	listserv@vml.nodak.edu	Downs Syndrome list
EAT-DIS	listserv@sjuvm.stjohns.edu	Eating disorders list
EMS-EDU-L	listserv@informatics.sunysb.edu	Covers emergency medicine
EPIDEMIO-L	listproc@cc.umontreal.edu	Epidemiology list
FAMILY-L	listserv@mizzou1.edu	Academic family practice list
HEPV-L	listserv@sjuvm.stjohns.edu	Hepatitis discussion list
HEM-ONC	listserv@sjuvm.stjohns.edu	Covers hematology/oncology
PEDNEFRO-L	listserv@limotol.cuni.edu	Pediatric nephrology list
PTHER-L	listserv@vm.ucs.ualberta.ca	Physical therapy and related fields
SKELDYS	mailserv@csmc.edu	Skeletal dysplasia list
SURGINET	listserv@utoronto.bitnet	General surgeons list

to log on to a remote computer and use its resources interactively, as if you were sitting right in front of it. Gopher is a menu-based approach to locating resources on the Internet, while FTP was developed to permit the transfer of files across the Internet. These capabilities offer the Internet user a rich array of information resources, but they can often be slow and somewhat difficult to use.

The rapid development of the World Wide Web (WWW) and the introduction of easy-to-use navigational software called "browsers" in the past three years have made "surfing" the Internet (perusing the resources) much less frustrating. The WWW is a graphics-based "point and click" system which links, finds, and presents many types of Internet resources in a simple and often intuitive format.

Access to Internet resources depends upon your client-server system. This means that you use a program, called a client, installed on your local computer to talk to a program, called a server, installed on a remote computer.

Kinds of resources available

Next we will discuss some of the kinds of resources you are likely to find using the basic capabilities noted above.

E-mail and Discussion lists

Electronic mail constitutes the largest activity on the Internet. There are a number of e-mail programs available, and which one you use may depend on the method by which you access the Internet (see **Providers** below). A popular extension of the e-mail concept are discussion groups, which generally take the form of either mailing lists, often referred to as **listservs**, or **newsgroups**. Electronic discussion lists are forums in which participants can post questions or information, which are then seen by all other participants.

Listservs form around specific topics and use e-mail to send all messages to each list participant or subscriber. There are thousands of lists available, and many are devoted to various medical specialties and related

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Table 2. Telnet & Gopher sites

Name	*Address*	*Notes*
Telnet		
Library of Congress	locis.loc.gov	No password required
National Library of Medicine	locator.nlm.nih.gov	Login as: locator
Federal bulletin boards	fedworld.gov	Includes hundreds of federal boards
Gopher		
Dana Farber Cancer Institute	farber2.dfci.harvard.edu	
National Institutes of Health	gopher nih.gov	Includes much cancer information
National Institutes of Allergy and Infectious Disease	gopher niaid.nih.gov	
National Library of Medicine	gopher.nlm.nih.gov	Includes the NIH-sponsored "Clinical Alerts"

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topics. Some have a human moderator, who makes judgements about which messages should be distributed to list subscribers; many do not. Having a worldwide community of experts available to you for consultation and sharing of information quickly can be extremely worthwhile. Many medical journals now routinely include an Internet column, and listserv addresses frequently show up there. Your medical librarian can also familiarize you with methods of identifying listservs of interest.

Newsgroups are more like public bulletin boards, and which newsgroups you can read and send messages to will depend on which your Internet provider chooses to make available. Examples of discussion lists are given in Table 1.

Telnet

Telnet is commonly used to log in to databases or major libraries all over the world. One can telnet to **locator.nlm.nih.gov**, for example, to search the catalog of books and other resources at the National Library of Medicine in Bethesda, Maryland. Telnetting to **fedworld.gov** gets you to a gateway of nearly a hundred federal bulletin boards, and the National Technical Information Service. (Table 2)

Many fee-based databases from commercial vendors and other information services are also available through telnet log-in.

Gopher

Gopher is an Internet protocol or tool that provides menu-based access to resources including documents, directories, software, libraries, and cancer information, among others. With gopher you start from a local or "top level" menu and follow menu choices that can lead you to other gophers and resources located anywhere in the world. There are search mechanisms to help you locate useful gopher sites, as well; Veronica and Jughead are the colorful names for two such search programs. Useful gopher sites are listed in Table 2.

World Wide Web (WWW)

The WWW is by far the fastest-growing and most popular subset of the Internet. Hypertext transfer protocol, or usually just "http," is the protocol used to provide information on the WWW. Hypertext allows you to move around the WWW from one site or resource to another very easily and without having to know where the next desired resource is located: You just start at one site or "page" and move to another related page by clicking on a highlighted word or image on the page or screen at which you are looking. The software used to display the documents and images to the user is called a browser, and there are several excellent browsers available. Among the more familiar browsers are Netscape Navigator, Mosaic (both are free to non-commercial users and can be downloaded from sites on the Internet), and Microsoft Explorer. Audio and video media are also available through the WWW capabilities, giving rise to some exciting new hybrid resources such as the *Journal of Image-Guided Surgery* (http://igs.slu.edu), which features video clips in some of its articles. Many WWW pages now offer animation as well.

Many Internet resources and users are migrating away from the text-based protocols to the graphical and multimedia capabilities available through the WWW. Table 3 lists a sampling of medical WWW sites. Each Internet site and WWW page is identified by a Uniform Resource Locator, or URL, given in this format: protocol://Internet address/path/document, and most look similar to this: **http://www.slu.edu/**

The National Library of Medicine's Internet *Grateful Med* has recently become available on the World Wide Web and offers much greater ease of use and much more powerful search assistance through the Unified Medical Language Metathesaurus. If you have a *Grateful Med* user id and password and can access the IGM through the WWW, no additional software is necessary. The address for the IGM homepage is **http://igm.nlm.nih.gov.**

Equipment and providers

The equipment and software you will need to use Internet functions and resources depend, of course, on which specific functions and resources you want to use. For World Wide Web access, you'll need a fairly high-powered computer, a Macintosh (System 7 or above) or a 486 (or higher) PC with Windows. You will also need a modem (the faster, the better—14,400 bps or more for best performance), communications software, and a printer. There are several options to connect to the Internet. Many academic and government institutions and some large corporations make Internet connections available at little or no individual cost to faculty members or employees. Familiar commercial online services such as Prodigy, CompuServe, and America Online have begun offering gateways to the Internet as part of their subscription packages. In addition, many localities are now being served by "Internet service providers," companies selling access specifically to the Internet. Ask your medical librarian or someone in the Computing Services area of your hospital for suggestions about the most flexible, cost-effective and speedy methods of access in your area.

Conclusion

The impact of the Internet is already being felt in many facets of our work and personal lives. The potential is clearly here for electronic resources to improve the care provided to patients and to enhance biomedical research by connecting health care practitioners to the most up-to-date information available and to their colleagues around the globe. Resources abound in Cyberspace, just waiting for you to explore, identify, and use. Applications of currently-developing technologies using the Internet might well include electronic insurance claims submitted and paid via the Internet; online drug, instrument, and supplies catalogs and ordering; online specialty consultations; additional patient education sites; more electronic journals and texts; or perhaps Internet-accessible computer-mediated distance learning for continuing medical education. The current outbreak of online mania with more and more physicians discovering they can easily and inexpensively tap into all kinds of information has the clear potential to influence medical decision making, education, and research in important ways.

A few words of caution: Internet sources are extremely volatile. Addresses change as sources are updated, and often people move. The distributed nature of electronic resources can be both an advantage and a disadvantage. Some resources are unique to the electronic format (for example, *HeartWeb*, *Journal of Image-Guided Surgery* or *The Virtual Hospital*), while others are simply online versions of traditional books or journals. And not all sites are free; some require a subscription to move beyond a home page or opening screen. MoMed

Bibliography

There are many, many Internet books. Check your favorite library or bookstore to see what they have.

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Table 3 - World Wide Web sites

Name	*URL*	*Notes*
Organizations		
Alzheimer's Association	http://www.alz.org/	Media releases, position statements
American Cancer Society	http://www.cancer.org/	Shows grant opportunities
American College of Cardiology	http://www.acc.org/	Tables of contents & abstracts from recent JACC issues
American College of Physicians	http://www.acponline.org/	ACP journals' tables of contents & abstracts plus selected full-text
American Medical Association	http://www.ama-assn.org/	
American Society of Cataract and Refractive Surgery	http://www.ascrs.org/	Includes recent issues of society's journal
Radiologic Society of North America	http://www.rsna.org/	
World Health Organization	http://www.who.ch/	Includes weekly epidemiological record
Government sites		
Agency for Health Care Policy & Research	http://www.ahcpr.gov:8008/	Includes some clinical office practice guidelines
Centers for Disease Control and Prevention	http://www.cdc.gov/	Publications, statistics, funding opportunities
Dept. of Health & Human Services	http://www.os.dhhs.gov/	Includes links to many government sources
Food & Drug Administration	http://www.fda.gov/	
National Institutes of Health	http://www.nih.gov/	News, health and grant information
National Library of Medicine	http://www.nlm.nih.gov/	Includes book catalog and free databases
Journals		
British Medical Journal	http://www.tecc.co.uk/bmj/	
HeartWeb	http://webaxis.com/heartweb/	Peer-reviewed; multimedia features
Infectious Diseases in Children	http://www.slackinc.com/child/idc/idchome.htm	
JAMA	http://www.ama-assn.org/journals/standing/jama	Must register to use, but no subscription cost yet
Journal of Image Guided Surgery	http://igs.slu.edu/	Includes multimedia
Modern Healthcare	http://www.modernhealthcare.com/	
Morbidity and Mortality Weekly Report	http://www.cdc.gov/epo/mmwr/mmwr.html	Includes index from 1993-96
Nature	http://www/nature.com/	
New England Journal of Medicine	http://www.nejm.org/	Fulltext of some features
Vaccine Weekly	http://www.holonet.net/homepage/1v.htm	Some fulltext, some abstracts

Table 3, Continued... World Wide Web sites

Name	*URL*	*Notes*
Medical Images Sites		
Image Engine	http://dublin.smi.med.pitt.edu/	Wide range of resources: gastroenterology procedures such as colonoscopy, upper GI endoscopy, oncology specimens. Numerous links to other sites
LARG*net Medical Image Access/Medical I-way	http://johns.largnet.uwo.ca:80/	Includes images of the skull and face, lung, heart, skeletal system, gi and gu systems
University of Leeds, England Centre of Medical Imaging Research	http://agora.leeds.ac.uk/	Many links to additional image sources in U.S., Europe and Asia
WebPath	http://www-medlib.med.utah.edu/WebPath/webpath.html	Clinical & general pathology
Whole Brain Atlas	http://count51.med.harvard.edu/AANLIB/home.html	
Miscellaneous sites		
Doctor's Guide to Medical Conferences & Meetings	http://www.pslgroup.com/MEDCONF.HTM	
Hospital Web	http://neuro-www.mgh.harvard.edu/hospitalweb.nclk	Growing list of hospitals with Web sites
Mental Health Net	http://www.cmhc.com/	
Physician's Guide to the Internet	http://www.webcom.com/pgi/	Includes top medical news stories each day
RxList	http://www.rxlist.com/	Indications and side effects of drugs
Sterling Clinical Resources	http://alpha.creditnet.com/sterling/	Clinical trials of rare chronic disorders treatments
Virtual Hospital	http://vh.radiology.uiowa.edu/	
University of Kansas Dykes Library List of Biomedical Internet Resources by Subject	http://www.kumc.edu/service/dykes/RRPAGES/rrintro.html	These resources are reviewed by librarians and are checked regularly for viability

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Here are a few we've found very helpful, but many other good titles are also available.

Gilster, Paul. *The New Internet Navigator*. New York: John Wiley, 1995.

Hahn, Harley. *The Internet Complete Reference*, 2nd ed. Berkeley: Osborne McGraw-Hill, 1996.

Hancock, Lee. *Physicians' Guide to the Internet*. Philadelphia: Lippincott-Raven, 1995.

Krol, Ed. *The Whole Internet: User's Guide and Catalog*. 2nd ed. Sebastapol, CA: O'Reilly and Associates, 1994.

Levine, John R., Carol Baroudi, and Margy Levine Young. *The Internet for Dummies*, 3rd ed. Foster City, CA: IDG Books, 1995.

It's hard to pick up several journal issues and not find at least one or two papers on some aspect of the Internet. Here are just a few we have found useful.

Glowniak JV. Medical resources on the Internet. *Annals of Internal Medicine* 1995 July 15;123:123-31.

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Telemedicine, the Internet and the Medical Student

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Washington University Medical Student

Although telemedicine refers to the use of telecommunications technologies to provide medical services, it is increasingly applied to the use of computers in medicine and more recently to the Internet and the World Wide Web. Telemedicine has been around since 1959 when Wittson[1] used a microwave link to conduct psychiatry consultations. Since then there have been many experimental uses of telemedicine but it was not until the World Wide Web (WWW) that the explosion of medical information on computer networks began. There are thousands of sites on the WWW run by hospitals, medical schools, medical organizations and individuals that contain a stunning array of medical information. From radiology tutorials to the Visible Human Project to Washington University's pathology slides, medicine has stormed the WWW and is there to stay.

The World Wide Web

There Internet began in 1969 when the U.S. government created ARPAnet (Advanced Research Project Agency network) to allow scientists working on government contracts to share mainframe computer time. The decentralized network could send information split into tiny bits, each traveling to its destination via a different route and would thus theoretically be impervious to nuclear attack. During the 1980s, university laboratories began signing on to the network, using it to transfer files and send e-mail. However, as more and more laboratories logged on compatibility problems increased. The solution was the WWW. A collection of Internet users led by CERN (The European Particle Physics Laboratory in Sweden) decided upon a standardized protocol for placing information on the Internet called HyperText Markup Language (HTML). This language, like the earliest word processing programs combines text with embedded formatting commands. (Today's word processing programs do essentially the same thing but you cant' see the formatting commands.) As Hypertext, any words or icons can be a link to other documents through specific addresses or uniform resource locators (URL). The URL is a combination of the address of the Internet computer that hosts the information and the filename of the information. As the hardware connecting computers and the software for navigating the Web improved video, then sound and now film were able to be incorporated into the Web. Meanwhile, businesses, and online services which already had thousands of computers networked began joining the Web. Now there are millions of people using the web with millions more logging on every month.

Medicine and the WWW Today

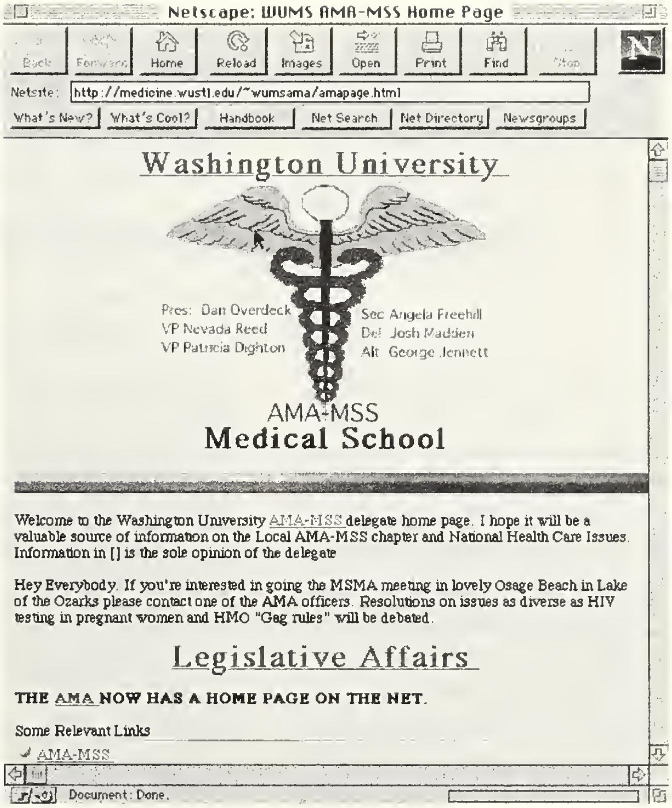
There is an extraordinary amount of medical data on the Web. Obviously certain fields of medicine lend themselves to the web. Radiology and Pathology which rely heavily on imaging were the first to invade the net. The placement of images on the Internet is of particular interest to students because they can use these images to learn efficiently (and the digitized images don't fade like slides.) The Visible Human Project and the Whole Brain Atlas have placed high resolution images of human anatomy at a central database where they can be accessed by students and physicians all over the world. The CDC keeps the *Morbidity and Mortality Weekly Report* online as well as a new journal, *Emerging Infectious Diseases*. There are lists compiled of the hundreds of hospitals and medical institutions online. However, most of these resources are static. Even the few case studies and teaching programs contain very little interaction and what there is has been pre-programmed. Yet as more individuals log on and hardware speeds up signal transmission, the possibilities of real time, cost effective communications between vast numbers of people increase.

Medicine and the WWW Tomorrow

The real hope for telemedicine has always been the cost-effective delivery of high-quality health care to underserved areas. In the near future, radiology, pathology and dermatology consults might be made via e-mail and the static imaging already online. Even, video and real-time applications, like psychiatric interviews are in the conceivable future as are displaying electorencephalograms and electrocardiograms. (These would be of great benefit even within an institution let alone over long distances.) All of these would give rural physicians the ability to consult specialists at major medical centers without the cost and stress of travel...either for the physician or more importantly, for the patient.

Imagine in the year 2000 a man vacationing in the Ozarks is hit by a care and rushed unconscious to the emergency room. The attending physician calls a special number and obtains a password allowing her access to all the man's medical records including x-rays and medications. With this information she is able to continue the correct dosage of his digitalis prescription avoiding possible heart failure or MI. However, she needs a consultation on his electorcardiogram. She transmits it to a cardiologist who e-mails back his diagnosis.

The technology for the above scenario is already in place at many institutions. As medical records go online and more and more departments use the Internet this type of situation will become increasingly likely. Inexpensive, real-time video however, is still impractical. The *national information infrastructure* is fast becoming a reality. Many companies and the federal government's High Performance Computing and Communications Program (HPCCP)[2] are conducting research to increase the speed of data transfer facilitating real-time video transmissions. Eventually the beginnings of virtual surgery today may become the remote endoscopic surgery tomorrow.[3]



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AMA-MSS
Medical School

Welcome to the Washington University AMA-MSS delegate home page. I hope it will be a valuable source of information on the Local AMA-MSS chapter and National Health Care Issues. Information in [] is the sole opinion of the delegate

Hey Everybody. If you're interested in going the MSMA meeting in lovely Osage Beach in Lake of the Ozarks please contact one of the AMA officers. Resolutions on issues as diverse as HIV testing in pregnant women and HMO "Gag rules" will be debated.

Legislative Affairs

THE AMA NOW HAS A HOME PAGE ON THE NET.

Some Relevant Links

AMA-MSS

Washington University and the WWW

Washington University has placed a great deal of information on the Internet in a very short time, primarily for education. Students have electronic access to thousands of histology and pathology slides. These resources will eventually be connected to each other, so students can move from pathologic to normal tissue easily, and to text that explains the image. Meanwhile, the radiology department, through the section on nuclear medicine, has cases of unknowns with and without diagnosis. In addition, some students and student organizations have their won web sites. The Young Scientist Program at Washington University has begun an ambitious project on the Web that will allow high school students to ask science questions that will then be answered by graduate and medical students at Washington University. The AMA-MSS chapter at Washington University maintains a Web site that allows access to local chapter information as well as a Legislative Affairs site that covers issues of health care legislation and reform such as student loans and Medical Savings Accounts.

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Conclusion

The Metcalfe rule, named for the creator of the Ethernet standard for PC Networks Bob Metcalfe, states that a network's value is proportional to the number of users squared. The Internet has doubled in size every year since 1988. There may be as many as 25 million people using the Web, crating millions of home pages in just the last couple years. Its value is growing enormously. While companies have been talking about the Information Superhighway and the government has talked about the electronic infrastructure, individuals have been creating it. Now, as businesses begin to catch on they will provide faster networks as well as greater commercialism, but they will not be able to determine the information available on the information superhighway as they might have hoped. Instead, individual users have already staked their claim, for better or worse, as the purveyors of knowledge on the net.

Medicine could take advantage of the speed, ease and quality of imaging that the net provides, thus, increasing communication, providing access for underserved, and decreasing costs. This has already begun. However, care will be needed. Using technology for technology's sake is neither cost-effective nor good medicine. We must remember that much of medicine is based on the doctor-patient relationship and while technology continues to alter that relationship is must not damage it.[4-7] **MoMed**

The WWW a Brief Tutorial

There is a great deal of software available to navigate the World Wide Web, though the most popular is Netscape which is free to not-for profit users including education institutions. It uses an intuitively understandable graphical interface. As discussed above, to find a location on the Internet you need its URL. For example, the AMA-MSS page at Washington University is:

http://medicine.wustl.edu/~wumsama/amapage.html

Hypertext Transfer Protocol
Host Name (where the file is)
What Directory Contains the File
The File Name

There are other protocol besides http, like gopher or FTP (File Transfer Protocol). Once you have reached this page there will be text in black and dark blue on a light blue background. The dark blue text links to other pages. For example, clicking on the mouse on Legislative Affairs will take you to the Washington University AMA-MSS Legislative Affairs Page. In addition, there are sites for a Multi-Media Medical Reference Library, AIDS Information and Government servers at the White House and Congress.

Addresses of selected sites mentioned in this article

CDC	http://www.cdc.gov/
Congressional Information	http://thomas.loc.gov/
Mallinckrodt Institute (Washington Univ. Radiology)	http://www.mir.wustl.edu
Multimedia Medical Reference Library	http://www.tiac.net/users/jtward/index.html
Netscape	http://Netscape.home.com/
Red Ribbon Network (AIDS Information)	http://worldclass.com/redribbn/
Visible Human Project	http://www.nlm.hih.gov/research/visible/visible_human.html
Washington Univ. AMA-MSS home page	http://medicine.wustl.edu/~wumsama/amapage.html
White House	http://www.whitehouse.gov
Whole Brain Atlas	http//count51.med.harvard.edu/AANLIB/home.html
Young Scientist Project	http://medinfo.wustl.edu/~ysp

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Physician-Hospital Integration: Legal Issues Affecting the Development of Management Services Organizations

Sandra H. Johnson and Phillip A. Rothermich

Most physicians want to increase efficiency in their practices, especially as to administration and management, and want to deal more effectively with the new contracting environment. At the same time, hospitals and other health care organizations are seeking business relationships with physicians to increase their own competitive position and offer the package of care that purchasers increasingly desire.

For these reasons, many physicians and medical practice groups are considering or have entered into business relationships with hospitals and other organizations. In physician-hospital relationships, several models have developed, including the physician-hospital organization (PHO), management services organization (MSO), captive medical group models, and several other forms of integrated delivery systems (IDSs) in which physician practices play a key role. Because the management services organization typically allows physicians to remain somewhat autonomous, it is often an initial step for physicians and hospitals exploring integration.

MSOs generally provide an array of managerial, administrative and support services to medical group practices. These may include space, equipment, staffing, billing and collection, claims processing, marketing, utilization and quality management systems, physician recruitment programs, accounting, group purchasing, insurance and risk management. An MSO can bring together several independent small practices for more effective and more efficient contracting with managed care plans.

MSO services are often set up through a series of transactions. For example, a comprehensive MSO might purchase some or all of the tangible assets of the medical practice through a purchase agreement. It can provide facilities and equipment to the practice through leasing arrangements. It can provide information systems, personnel, and many other administrative services under a management services contract. MSOs often provide services by subcontracting to another organization. Physicians pay the MSO for services received, and payment typically is based on a fixed monthly fee, a rolling percentage of practice revenues or a cost-plus scale.

MSOs take on a variety of organizational forms. For example, they can be established simply as an activity or function of the hospital, or as a separate legal entity which may be owned by the hospital or, more commonly, by the hospital and physicians jointly. Composition of the governing body of the MSO, particularly as to physician representation, varies among MSOs. Physicians selling practice assets to an MSO owned jointly by the physicians and the hospital may receive cash (or equivalent), an equity interest in the MSO itself or a combination of both.

The development of any physician-hospital integration structure requires analysis of numerous legal constraints as applied to the facts of the specific situation. Some of the legal issues that must be considered both by physicians and hospitals in the development of an MSO are discussed in this article. Though this is by no means a comprehen-

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sive list, it highlights the regulatory issues likely to occur.

For purposes of discussion here, the issues have been grouped into more general topics. The first section concerns restrictions on the business relationships of health care providers that receive Medicare or Medicaid payment. The second identifies issues that arise if the organizational partner (e.g., the hospital) is federally tax exempt. Third, some issues concerning the tax treatment of compensation to physicians affiliating with the MSO are discussed. The final section identifies selected state law issues.

1. Medicare/Medicaid Regulation of Business Relationships

In MSO arrangements, two primary areas are likely to stimulate concern over Medicare and Medicaid fraud and abuse laws. The first occurs when management services are undervalued and are provided to the physician at below-market rates, allowing an inference that remuneration (the difference between the agreed upon price and the value of the services) is being provided in exchange for referrals to the hospital by the physician. The second arises when the physician-MSO agreement itself appears to require that the physicians refer patients to the hospital or its designated providers. If Medicare and Medicaid fraud and abuse prohibitions are violated, both the hospital and the physicians can be subject to significant civil and criminal penalties. Generally, however, most MSO contracts can be structured (in terms of compensation, performance obligations and accurate valuation of assets) to minimize fraud and abuse concerns.

The Stark prohibitions against self-referral may also be triggered in an MSO. Specific exceptions to the Stark prohibitions may apply to the MSO-physician relationship, but the scope of such exceptions is not entirely clear. Through proper structuring of the MSO-physician relationship Stark problems can be avoided entirely.

2. MSOs Involving Tax-Exempt Organizations

If the entity establishing the MSO is federally tax exempt, a number of issues relating to federal regulation of tax-exempt entities will be brought to the table by the tax-exempt organization, whether or not the MSO will itself attempt to gain tax exempt status. These issues relate primarily to physician compensation, broadly defined, and to the equity structure and governance of the MSO.

From the perspective of the tax-exempt hospital, physician compensation includes the purchase price (which may include an equity stake in the MSO) for assets transferred from the doctor to the MSO; salary or other compensation for services provided by the physician; and payment to the MSO for management services or facilities provided to the physician. In each of these exchanges, the prohibition against private inurement requires that the tax-exempt hospital assure that payments for assets and services reflect market value.

The IRS examines the equity participation and governance structure of any joint venture in which a tax-exempt organization participates, including MSOs. Physicians may share profits and may participate in the governing body of the MSO, but generally only commensurate with their financial investment in the MSO. The tax-exempt hospital may provide the physician with financing to enable the physician to reach a greater investment level so long as the financing is offered on commercially reasonable terms. The IRS has identified other governance restrictions as well, relating primarily to conflicts of interest of physician members of the board.

3. Federal Tax Treatment of Compensation and Benefits

Several problems often arise in developing the appropriate employee benefits and retirement plans for both the MSO and the physician entity. The tax treatment of the physician's income and benefits also may be affected by the MSO agreement.

The MSO structure usually includes a legal relationship between the hospital and individual physicians, which involves some control by the MSO over the physician practice. This may create an explicit employment relationship or a contract under which the MSO and the physician act as independent contractors.

Likewise, other practice employees may become MSO employees or may be subject to certain management control by the MSO. If the MSO agreement results in too much control being exerted over an individual physician or other practice employees by the MSO, the IRS may be able to assert that such individuals are actually employees of the MSO for tax purposes, even though the parties do not consider themselves to be in an employment relationship and have specifically disclaimed an employment relationship in their agreement. If individuals are deemed employees under applicable rules, the MSO must withhold federal taxes (including FICA and FUTA) from wages and salary.

The "affiliated service group" rules of the Internal Revenue Code may apply to the MSO and physician entity. If the MSO and physician entity must be aggregated under those rules, the retirement plan and other benefit levels of both entities will be considered together in applying the non-discrimination tests required under the Code, in terms of benefit levels of highly compensated individuals, for example. This issue creates a structuring challenge as the MSO and the practice entity, which often have very different benefit levels, come together.

4. Selected State Law Questions

Restrictions on the corporate practice of medicine and fee-splitting can affect the structure of the physician-MSO agreement. The corporate practice of medicine doctrine has not been a particular concern in Missouri, although it is an issue in several states and can be latent for a long time and then re-emerge. The long-term management agreement between the MSO and the physician entity can be structured to avoid problems with corporate practice. Restrictions on fee-splitting will influence the financial relationship between the MSO and the physician, particularly as to the basis of payment for MSO services.

Moving an independent physician practice into relationship with an MSO may raise other state law claims. For example, theories of tort liabilty may shift, and employment law issues may develop that may not have affected the physician in an independent practice.

Conclusion

There are no cookie-cutters for the structuring of physician-hospital relationships in the contemporary environment for medical practice. The facts and circumstances will certainly affect the attractiveness of the MSO to the physician and will influence how a particular MSO is structured. However, through careful planning, legal and regulatory issues raised in the development of the MSO generally will not prevent the parties from achieving their goals. MoMed

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Physician Directed Networks: The New Generation of Managed Care

Tom Bennett, M.Div., MBA, MSW, GCG, Executive Vice President
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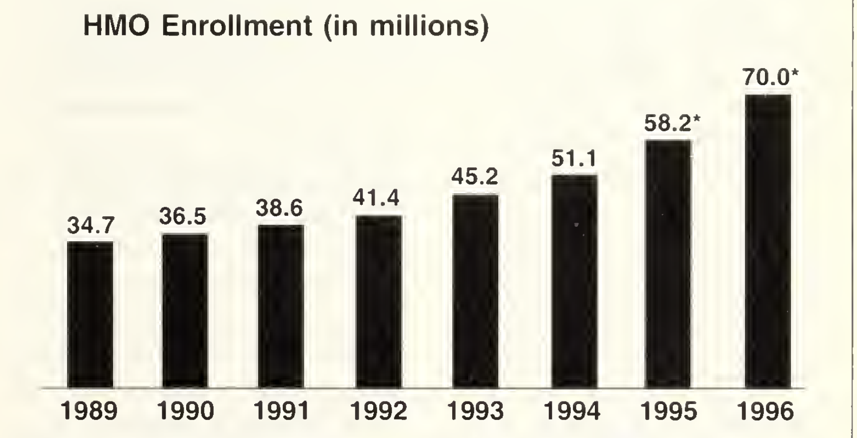
Daniel O'Sullivan, MD, President, Missouri State Medical Association
and Missouri State Medical Services, Inc.

"The pace of events is moving so fast that unless we can find some way to keep our sights on tomorrow, we cannot expect to be in touch with today." - *Dean Rusk*

As the U.S. health care industry undergoes the most dramatic changes in its history, large managed care organizations are attempting to gain greater control of the market. These changes include the dramatic growth of managed care plans and their exponential rate of enrollment. According to the American Association of Health Plans, there are currently 58.1 million people enrolled in HMOs nationwide. 1995 witnessed a record enrollment of 7.7 million individuals, an increase of 14% from 1994. Enrollment for 1996 is expected to reach 70 million people (Diagram 1). PPO enrollment is currently at 91 million, an increase of 15% over the previous year.

Providers have evolved as well. There is rapid movement of physicians who are consolidating and integrating into health care delivery networks and multispecialty groups, which provide services to these health plans. These *Physician Directed Networks* have grown, and will continue to grow, because they have responded to the need to control health care costs. The current non-government medical inflation rate stands at 7%, as compared to 18% in the late 80s and early 90s, and according to HCFA, the Medicare inflation rate is projected to be 10.4 % for 1996.

Diagram 1



Market Dynamics

To fully understand the rising popularity of *Physician Directed Networks*, one has to be cognizant of the local, state, and national context of current dynamics in health care delivery.

These dynamics include:

- The increased cost of health care and the impact on the federal deficit.

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- The exponential growth of enrollment into managed care plans as a vehicle to contain the cost of health care; the aggressive marketing by managed care organizations (MCOs) to senior citizens.
- The rapid movement away from hospital-centered care to the more cost efficient community-based care and the dramatic reduction in length of stay and admissions with the consequent over capacity of hospital beds.
- Shifting capital away from MCOs and hospital systems into *Physician Directed Networks* and physician practice management organizations, out-patient facilities, alternative delivery sites, and group practice.
- Movement away from gatekeeping and capitation with more focus on case and medical management of high risk patients and high cost procedures.
- National impact of the decision by the Minneapolis Business Health Care Action Group, to circumvent MCOs and contract directly with providers; purchaser's demands for value and for information from providers in order to make informed decisions about purchasing health care services.
- The epic struggle for control of the health care economic exchange between providers and purchasers and insurance companies and MCOs.
- The strategic, synergistic partnerships of physicians, ancillary providers, and vendors. Consolidation of hospital systems, insurance companies, MCOs, ancillary providers, vendors, and physicians.
- Entry into the marketplace of major investors and vendors who are attempting to capture the health information technology (HIT) market, which according to Smith/Barney is projected to increase to $20 billion within the next four years. The investor list includes such giants as Microsoft, Kodak, Southwestern Bell, ATT, IBM, Sprint and Eli Lily. The advances in HIT may have the largest impact on the future of health care delivery control in the U.S.

The General Contractor

Many physicians were unprepared for the managed care revolution. However, most have now come to the realization that managed care, or rather, "managing care" is both a clinical and economic necessity, and that well-managed and well-organized physicians are committing heresy on a grand scale by preaching and practicing that salvation can be attained outside of the gospel of HMOs and MCOs.[1] Physicians are creating a new generation of managed care, i.e. one in which **patient care is managed and directed by physicians** in collaboration with other providers. Physicians have adapted well to the demands to establish more efficient operations and to put in place utilization management, quality assurance, high risk management, and strict credentialing programs.

Physicians are now beginning to question the fundamental role of HMOs as they witness the shifting of utilization management, high risk management, and the shifting of economic risk to the providers through capitated programs. By simply adding marketing and actuarial services, these physician organizations are serving the major functions of HMOs, namely: utilization management, claims management, marketing, actuarial analysis, and risk pooling. Consequently, physicians are now contemplating the logical next step: the creation of their own health plans which would change the role of the physician from being the provider to the role of general contractor, i.e. controller of the premium. *(Reference is made to the Northwest Arkansas Independent Physicians Association and Renaissance Health Care Partners of Kansas City, both of whom have their own health plans.)*

The Elements of the Delivery of Health Care

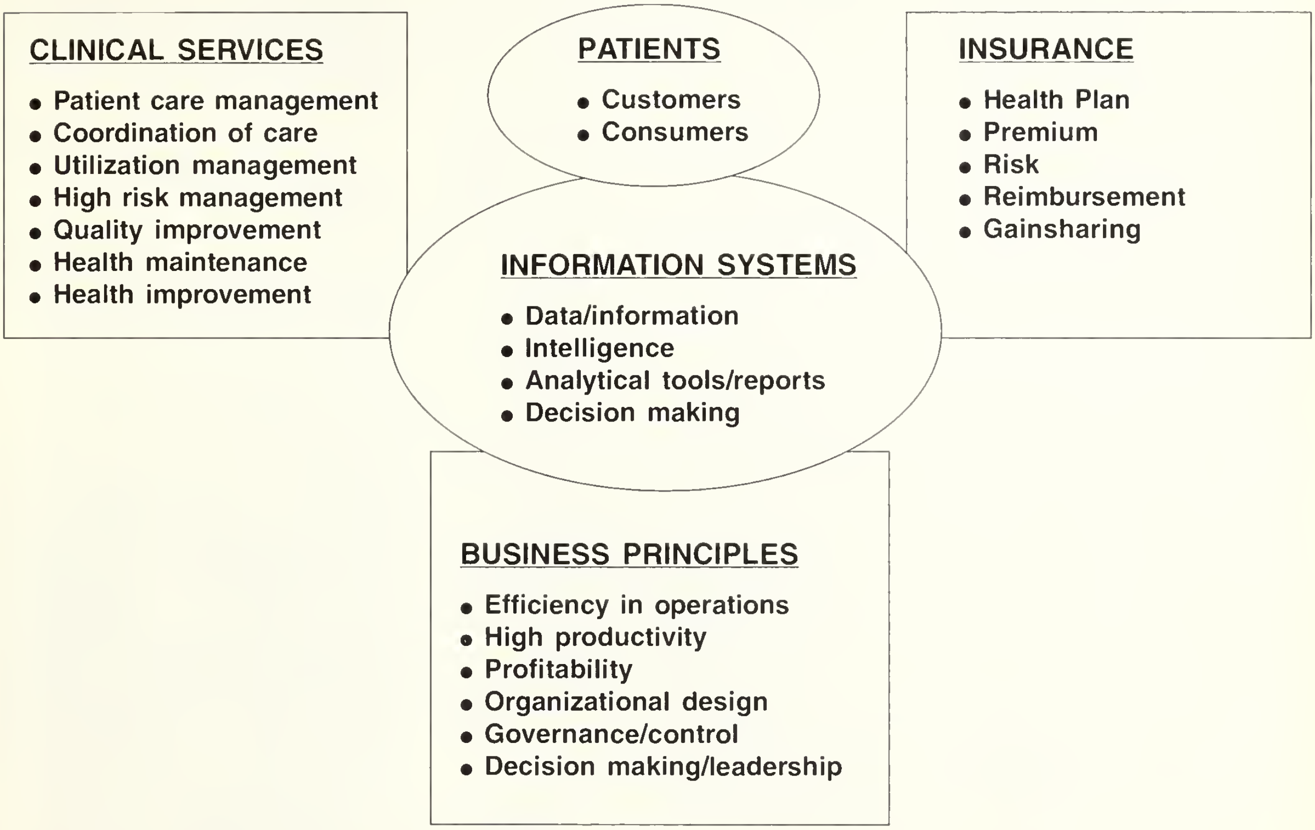
Diagram 2 describes the fundamental elements in U.S. health care delivery. In understanding and applying these core principles, physicians now have the opportunity and ability to control the very foundations of health care delivery:

Clinical services

- patient care management
- coordination of care
- utilization management
- high risk management
- quality improvement
- health education/health maintenance
- improved health status

Diagram 2

The Elements of Health Care Delivery



CLINICAL SERVICES

- Patient care management
- Coordination of care
- Utilization management
- High risk management
- Quality improvement
- Health maintenance
- Health improvement

PATIENTS

- Customers
- Consumers

INSURANCE

- Health Plan
- Premium
- Risk
- Reimbursement
- Gainsharing

INFORMATION SYSTEMS

- Data/information
- Intelligence
- Analytical tools/reports
- Decision making

BUSINESS PRINCIPLES

- Efficiency in operations
- High productivity
- Profitability
- Organizational design
- Governance/control
- Decision making/leadership

Business principles
- efficient practice operations
- high productivity
- profitability
- organizational design
- governance/control
- direction
- leadership

Insurance
- health plans
- premium control
- reimbursement
- risk
- gainsharing

Nota Bene: All three of these elements of health care are bound and interconnected through information technology systems.

Information technology
- connectivity/networking of sites
- clinical, demographic and business data/information
- analytical tools/reports produce intelligence
- decision making

Purchasers of Health care

Large employees and business coalitions/purchasing groups have become sophisticated, "prudent purchasers" of health care, and are seeking better value for their health care dollars. In January 1997 the Minneapolis Buyers Health Care Action Group (MBHCAG), which represents 23 major corporations in the Twin Cities area, will actively circumvent managed care organizations, and contract directly with well-organized and well-managed *Physician Directed Networks*. The goal of MBHCAG is to create a "Consumers Choice" model of care, and to give employees the freedom to use the best and most efficient providers.

Ralph Smith, president of the Houston Health Care Purchasing Organization, said, in discussing the role of HMOs, "It's like Las Vegas, when the house owns the actuarial numbers and makes the

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rules, the house usually wins. The HMO middlemen set the fixed premium for employers, push the risk onto the providers, then all gain goes to the HMO, while providers and employers take all of the downside. But employers and providers are finally figuring out that they can do better if they deal with each other directly."

The smaller employers, those that have between 2 and 200 employees, are not as sophisticated as the larger corporations, nor do they have the leverage of these large companies. They are not overly concerned about the type of health plan, i.e. a POS, Capitated, a PPO or an indemnity plan. However, they are demanding that their premiums remain stable; that they be given the necessary information to make informed decisions to control their health care cost; that their employees have access and choice of physicians. The Northwest Arkansas Independent Physicians Association is actually achieving the unthinkable, i.e. decreasing the premiums to these small companies.

Antitrust Relief for *Physician Directed Networks*

Poised and ready to assist this new generation of managed care is legislation that is pending in Congress in the budget reconciliation bills (H.R. 2491, H.R. 2530 , "Presidents" bill) and the "Antitrust Health Care Advancement Act" which is sponsored by Rep. Henry Hyde. The heart of the Hyde bill is the relief from the current restrictive antitrust standards that are applied to *Physician Directed Networks*. The Hyde legislation is proposing to change the use of the "per se" standard that is currently used by the Justice Department/FTC, and substitute it for the "rule of reason" standard. This would force the FTC and Justice Department to demonstrate the fact that the exchanging of prices and other financial information is de facto anti-competitive.

The Federal Trade Commission should recognize the potential threat of insurer-based plans (Aetna/United Healthcare) to totally dominate and monopolize the market. If the FTC is indeed serious about providing more competition in the marketplace, and bringing more value to the consumers of health care, it (the FTC) should quickly begin the process of collecting data on the growth and development of health plans sponsored by *Physician Directed Networks*, and analyze which factors advance or hinder competition and thus create more value to the consumers.[2]

All of these bills fuel the ongoing debate over incentivizing the formation of *Physician Directed Networks* by loosening the antitrust restrictions and circumventing state control, and as providers become more capable of managing large amounts of risk, hence physicians become more inclined to organize their own health plans. The American College of Physicians, in concert with the American Medical Association (AMA), is actively lobbying the Federal Trade Commission to desist from taking any enforcement action that would hinder physician integration efforts. ACP emphatically urged that the FTC modify their guidelines to provide more flexibility for physicians, particularly for those networks and groups that do not share financial risk as defined by the policy guidelines.

Network Development

Physician Directed Networks have begun to proliferate throughout the country, and the AMA, state medical associations and local medical societies are not only endorsing *Physician Directed Networks*, but are actively supporting them financially. Specific reference is made to initiatives under the auspices of state associations in Missouri, Florida, New Jersey, Oklahoma, California, Texas, South Carolina, Minnesota, Arkansas, New York, North Carolina, South Dakota, Kansas, Pennsylvania, and Washington.

In concert with the national trend, the Missouri State Medical Association, through its wholly-owned subsidiary, Missouri State Medical Services, Inc., (MSMS) has not only endorsed and encouraged the formation of *Physician Directed Networks*, but has been involved in establishing these Networks throughout the State. MSMS, Inc. is now planning to establish a statewide Management Service Organization (MSO), which would greatly facilitate the formation, operations and continued development of networks and group formation.

Over the past 18 months Missouri has witnessed a dramatic growth of physician enrollment into *Physician Directed*

Networks. The networks listed below are just a sampling of networks that are either in place or a being planned:

Kansas City	Renaissance HealthCare Partners Metropolitan Physicians Alliance Womens Health Care Network Community Health Partners
St. Joseph	Riverside Group
St. Louis Metro Area	Bi-State Network Beacon-HealthKey Network First Physicians Care, Inc. ENT Specialist Network Regional Orthopedic Specialist Network The Metro Cardiology Network Crystal City/Festus Physicians Network Alton Area Health Care Network Womens Primary Health Care Gateway Physicians Network
Festus/Crystal City	East Central Missouri IPA
Washington	Four Rivers Physicians Directed Network
Joplin	MAKO Physicians Directed Network
Springfield	Health Choice Physicians Network
Cape Girardeau	Physicians Network of Cape Girardeau
Mexico	Audrain Regional Physicians Organization
Jefferson City/ Lake of the Ozarks	Mid-Missouri Physicians Network

Physician Directed Networks are changing functions as a contracting vehicle to developing strategies to recruit physicians, credential physicians, control utilization and maintain quality and service to patients. The networks must now provide the resources to assist physicians in their practice to become more productive and competitive.

Nota Bene: To be successful in the managed care environment, the Network must meet current operating and clinical standards, and deliver quality medical care that is cost-competitive with the care delivered by other managed care plans. These networks must focus on the three "Cs": Cost, Customer and Change;[2] they must therefore be competitive on price, service and quality.

For *Physician Directed Networks* to be attractive to physicians, they must not unduly intrude on the physician's medical judgement. They must afford the individual physician or group the ability to continue to manage their practice and to retain a certain amount of autonomy. However, those participating physicians must adhere to strict peer review.

Physicians who form *Networks* must act in a proactive manner rather than a reactive manner, and take advantage of the opportunities of contracting with payors and employers in delivering quality health care in a more cost-effective manner. For the *Networks* to be successful, they must implement sound business principles, and implement governance, clinical, operational and informational infrastructures that will assist the members to become more efficient and productive; thereby retaining and increasing the patient base.

Summary

The external pressure to reduce cost while maintaining quality and service is moving the whole industry into a rapid mode of integration. Hospitals, vendors, MCOs, and now, physicians, are faced with the difficult decisions concerning how their operations will be integrated into the larger health care delivery system. These pressures have forced physicians to consolidate, build leverage, and create efficiencies to become more productive; thereby better positioning themselves to respond to the challenges and the opportunities that lie before them. This initial phase of consolidation has given many physicians the momentum to begin to wrestle back the control of health care and the courage to design the next generation of managed care: Physician Directed Managed Care.

What will be the next phase? Perhaps, the next step will be fully-integrated specialty and multi-specialty groups leading to alternate delivery sites.

"Everyone thinks of changing the world, but no one thinks of changing himself." – *Leo Tolstoy*

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Recommended reading: Peter Boland, *Making Managed Health Care Work: A Practical Guide to Strategies and Solutions*, Aspen Publications, Gaithersburg, 1993.

Thank you to Lizabeth Starnes for the editing of this presentation.

Specialty Networks

Timothy McIntire, MD, MBA

Specialty networks are the latest trend in a long running episode of how we as physicians deal with the managed care revolution. While primary care physicians often have preliminary access to patients, and hospitals are often the facility of choice for acutely ill patients, the specialist physician is the one who is expected to manage the most critically ill patients with the best use of resources at his or her disposal. A pen in the hand of a specialist is often the most expensive piece of equipment seen in health care today. But, if specialists are so important to the mix of current health care, why are they being taken advantage of in the marketplace?

Specialist physicians are now becoming aware of the economic forces of an efficient quality product, an oversupply of physicians, a decline in the growth of medical expenditures, and the massive consolidation of a formerly known "cottage industry" called health care.

Background Economics

U.S. health care spending grew rapidly in the 1980s, outstripping rates of growth in most of the rest of the economy. From 1980 to 1995, U.S. spending on health care as a percentage of GNP surpassed that of our industrial counterpart nations. These growth trends are expected to continue for the next decade. Because there is no significant evidence that this increased spending has better general health outcomes for the population as a whole, these spending trends have sparked increasing notice and response from business and government alike.

Most Americans receive their health care through third party payment, thus are not intelligent consumers as it relates to the direct costs their health care decisions effect. The normal factors which constrain buyers and sellers in free markets are distorted in the health care market, thus, Americans consume more health care, and this health care is more expensive per unit, than in any other country in the world. This distorted market invited the managed care revolution. In the mid-1970s, as U.S. industry began losing critical market share to newly aggressive European and Asian competitors, corporate budgets became scrutinized. The health care portion of these budgets was targeted as an area where restraint of the growth of expenditures was needed. U.S. industry naturally focused on health care costs to find savings which would help protect profits and provide critical investment capital.

Simultaneously, in the medical field, a surplus of physicians, especially specialist physicians in urban areas, was growing. The U.S. physician population grew by 180% from 1950 to 1990, while the U.S. population grew only 62%. As managed care has taken hold in many communities, and this specialist physician surplus has come to light, specialist physicians have been hard hit by public and corporate resolve to spend less on health care. The trend in declining specialist physician income became quite apparent in the early 1990s, and is expected to continue for some time to come.

Current Economics and Realities

Specialist physicians are now becoming aware of the economic forces of an efficient quality product, an oversupply of physicians, a decline in the growth of medical expenditures, and the massive consolidation of a formerly known "cottage industry" called health care. The economics of this situation would argue for specialists networks as a result of these economic forces. However, how these networks are developed will be the key in their success.

Quality Product Measurement

While many who are not familiar with HMOs think managed care leads to poor quality, recent data may not support those ideas. A May 1996 report released by the California Office of Statewide Health Planning rated 398 California hospitals on how they handled heart attacks. The study looked at the percentage of patients who died within 30 days of admission, then adjusted the death rates for the severity of each hospital's caseload. The researchers spent two years studying 68,012 heart attack cases occurring from 1990 to 1992 at these 398 hospitals. In the San Francisco Bay area two medical centers were judged to have significantly better outcomes than expected: California Pacific Medical Center (private) and Kaiser-San Francisco. Kaiser, the granddaddy of managed care! Other studies have shown that patients in HMOs have lower ruptured appendix rates than similar patients in fee for service systems. HMOs also get better compliance in preventive health categories, and they often have significantly less out of pocket expenses for patients.

Specialist physicians, if they are to carve out a niche in the health care market, be it local, regional or national, must be able to compete on cost and product. Quality will be a given, and will be assumed by the buyers of health care at least for the next few years. While all specialists feel they are the most efficient physicians taking care of the sickest patients, it is difficult for any of us to quantify these characteristics. Many hospitals and HMOs are pooling data to prepare profiles on physicians to answer some of these efficiency questions. Many believe that the quality gap between more efficient specialists and less efficient specialists will be minimal. This gap should lessen further as data is shared with less efficient specialists in an effort to change their practice habits to more efficient methods of patient care. Thus, competing on "a better product" will be hard to measure, and when it is measurable the differences between groups of specialists may not be that great.

Kaiser, the granddaddy of all HMOs, was judged to have significantly better outcomes in a recent study of California hospitals treating heart attacks.

Oversupply

The second economic concern with specialists is the oversupply, especially in the urban areas. No patient goes to a hospital or a physician with the notion that the health care provider will do a bad job. Patients assume quality. They assume that if a hospital is in business, or if a doctor has an office that they must be pretty good. With this in mind, HMOs and patients alike see very little difference between hospitals and specialist physicians. (There may be isolated exceptions to this theory where the choice of health care providers is limited, i.e. rural areas of the state.) If patients are not "brand loyal" to certain hospitals and specialist physicians, especially if their employers who buy their health insurance are not "brand loyal," then a surplus pool of specialist physicians would not be able to compete on product differentiation.

Cost

The third economic indicator for competition in the market is cost. Cost can take several different avenues. Cost could mean low fee-for-service reimbursement. Cost could mean accepting capitation or partial capitation so that the HMO's budget or employer's budget of medical expenses is predictable, thus manageable in their eyes. To compete on cost, physicians must change their mindset of managing mostly their practice revenues and begin to aggressively manage their practice expenses. To

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maintain a steady profit in the face of decreasing revenues, one must decrease the cost of practicing medicine. Management of cost is often achieved by economies of scale (larger groups of specialists or multispeciality groups with broader geographic coverage to make them more marketable to purchasers of health care), professional management, group purchasing agreements, employee skill mix strategies, strategic HMO contracting, strategic alliances and partnerships, etc..

Consolidation

Because managed care in the midwest has been preceded by changes in the far west, Minnesota and the eastern states, we can often study these geographic areas as leading indicators for what changes we can expect in Missouri. Consolidation of hospitals and physicians is the hot topic of the day. It seems that small groups just cannot achieve the inertia, economies of scale or leverage needed to be successful in our rapidly consolidating field. More and more hospitals are aligning with physician IPAs and/or multispecialty groups. These physician groups are especially valuable if they have a good mix of primary care physicians, strong internal management and strong, proactive physician leaders. The challenges of survival in medicine of the 1990s has even made past competitors become companions.

In May of this year The University of California at San Francisco (UCSF) and Stanford University Medical Centers entered into merger talks. These long time rivals found that they could not compete in the current California market because of their university cost structures, university needs and excess numbers of specialists. Managed care pit these two prestigious medical centers against each other, delivering patients to the lowest bidder. Through a merge they hope to gain intermediate savings from consolidation of their information systems, marketing, billing and purchasing departments. Long term expected economies would come in the specialized clinical programs through a "mega-hospital," which would be better able to compete for research funds and have access to a much larger pool of patients.

Specialist physicians often have the capital to begin this consolidation, but fail in their attempts by a lack of coherent vision and a lack of a group mentality.

The month of May also saw a merger between the physicians of UCSF and the private practice physicians of the California Pacific Medical Center IPA. This super IPA should be able to support the specialists at UCSF with the primary care base and broad geographic coverage Cal. Pacific possesses. Here is an example of specialists "wrapping themselves around" an IPA with two desirable attributes, geographic base with broad primary care.

Potential of Opportunities

Specialists must be agents of change. They must take the first, aggressive steps in changing the clinical paradigm. Specialists used to high-tech, invasive, procedurally intensive modes of practice may soon find themselves with a lot of time on their hands. Specialists must become managed care friendly. A clinic's early involvement with managed care and capitation can help in the development of a good relationship with HMOs, leading to an advantage in the market place. Specialists who push prevention and favor low-tech treatments will be viewed favorably and potentially rewarded with volume and pricing advantages. Specialists need to get serious about finding ways to save on cost to the payor. Cost effective medication as well as diagnostic testing and treatment will be of great benefit to all. While a liberal approach to picking new technologies (organ transplants, artificial hips, genetically engineered drugs and other dazzling advances) has put health care spending into high gear, many studies have shown that quality medicine can be cost-effective medicine. Specialist physicians know better than anyone that the effective use of medical resources is an achievable goal in a quality practice.

With the consolidation of health care currently accelerating, physicians will fare much better as they align in group settings. The proper alignment strategy varies, and depends on your needs, your market position, your specialty and your local managed care situation. Specialist physicians often have the capital to begin this consolidation, but fail in their attempts by a lack of coherent vision and a lack of a group mentality. Organizational skills and control of personal egos are the two attributes that allow specialist groups, IPAs, etc. to gather momentum in a fragmented, highly specialized, niche market such as specialty health care. Many experts believe that, with the exception of Behavioral Medicine, specialty IPAs or groups will only be moderately successful in the short run, and are destined for inefficiencies and competitive problems as full service multispeciality groups and IPAs become more dominant in the marketplace. If specialists look to organize into networks or groups as a transition model to deal with their current threats, and then continue to look for higher levels of integration with other physicians, the economic forces affecting their current practices may be tempered. The concept of a "wrap-around" IPA, multi-specialty or primary care group should be the goal to survival and growth for every specialist.

Conclusion

The most important concept we as physicians must recognize in our current practices is that medicine is a consolidating industry, and to practice in a consolidating industry we must first perform the business of medicine so that we can keep access to our patients, so that we can do the practice of medicine. Specialist physicians, while being the first to feel the brunt of these economic forces, may position themselves advantageously by understanding these changes and proactively, aggressively managing these opportunities.

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20 Factors To Consider When Negotiating a Managed Care Contract

Gary M. White, CPA, MBA

This article presents a checklist of 20 factors a practice should consider when negotiating a managed care contract. The negotiation of the contractual terms is at least as important as the capitation rate or fee schedule. With the advent of Medicare HMO Risk plans, the last bastion of patient choice is being eroded. Practices now are negotiating fees and terms with almost every plan. It is necessary for all practices to become knowledgeable in the intricacies of managed care contractual negotiation.

While our negotiating "clout" may vary with each managed care agreement we negotiate, here are 20 factors we should consider as we review, and negotiate a contractual relationship with a third party payor. This article complements my article in the March issue of *Missouri Medicine*, "Preparing a Per-Member-Per-Month Capitated Bid to a Managed Care Plan" which outlined a spreadsheet methodology whereby your practice could analyze utilization data to prepare a PMPM capitation quote.

1. Have the length of the contract be longer than one year; preferably a 3-5 year term as there is no incentive to become involved in preventive care with the patient population changing annually.

2. Have the practice be financially responsible only for the services you provide. You do not want to be "at risk" for ordering practices and fees of others.

3. If possible, specify the CPT-4 codes to be provided. This enables you to better estimate your utilization and exposure under the plan.

4. Include a separate payment mechanism for services beyond those specified. This could be discounted fee for service, a fee schedule, medicare fees or some other alternative.

5. Consider stop loss or reinsurance for excessive utilization. For capitated contracts consider a deductible of at least $5,000. The coverage could be on an individual basis, on an aggregate basis, or a combination of both.

6. Review carefully both the reinsurance deductible and managed care plan co-insurance factors when shopping for stop loss coverage as the premium can vary widely depending upon how the reinsurance carrier defines the costs. Some carriers may reduce reinsurance by patient deductibles, copays, payor discounts, etc.

7. Consider plan benefit and copay provisions with respect to impact upon plan utilization. Differences in levels of patient deductibles have an effect on plan usage.

8. If a capitation contract, is the patient copay in addition to cap rate? If not, cash flow to the practice is reduced.

9. Attempt to obtain guarantees from plan re minimum levels of plan membership as the smaller the number the greater impact of

outliers. Also, try for conversion to some type of fee for service if membership falls below defined levels.

10. Exclude "Favored Nation" clauses. These clauses force you to give the plan the lowest rate you give any other payor. If you cannot get this removed, try to include limiting factors such as qualifying plan size, etc.

11. Try to eliminate "Hold Harmless" clauses as many of our malpractice carriers will not honor them. Hold Harmless clauses can shift malpractice liability to the physician if the managed care plan is sued in connection with the physician's care to the plan member. Restrictions in the plan such as prior authorization, referral restrictions, utilization limitations, coverage issues, and other restraints imposed under the umbrella of cost containment may affect medical judgement. If a malpractice suit occurs, the doctor, under the hold harmless clause, agrees to assume complete responsibility. Always contact your malpractice carrier about the specific contractual clause to obtain written approval in advance.

12. Make sure all contract clauses are bilateral. Clauses which restrict one party only should be avoided. If such a clause must be included, have it apply to all parties.

13. Limit requests for medical records to specific reasons and ask for a fee to provide same. Otherwise, you may become involved in situations where numerous medical records are requested requiring staff time and supply costs.

14. Try to have plan accept your practice's forms rather than unique plan forms.

15. If there is a "termination without cause" section in the agreement, try for several months advance notice requirement.

16. Do not accept an "Exclusive Contracting" provision which limits your ability to participate in other plans.

17. Try to exclude any contract assignment provisions without prior approval. If the plan is sold or merged into another, you may wish to have the opportunity to renegotiate, or cancel the agreement.

18. How are perceived performance deficiencies by the practice resolved and corrected? Are the time frames realistic?

19. Obtain specific examples of types of data and reports they use for UR, outcomes, peer review, etc. Are they acceptable to you? Do they require you to participate in their UR, peer review, etc. programs? Are you reimbursed for your additional time?

20. Identify how patients will be referred to the practice, and under what conditions or diagnoses will PCP treat versus specialist?

I have shared with you my "Top 20" list of factors I consider when reviewing managed care contracts. There are many more factors to consider and you should have an outside consultant such as Missouri State Medical Services, Inc., a health care attorney or other health care specialist assist you in this process. There are also many other programs, seminars and books on the subject of managed care contracting, including capitation. With the rapid growth of managed care plans and Medicare Risk HMOs, especially in the metropolitan areas, we all need to quickly increase our expertise in this area. MoMed

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The Issue of Universal Health Insurance Won't Go Away
Employment Based Insurance Is Not Working

Arthur Gale, MD, MSMA AMA Alternate Delegate

In years past there has been considerable public discussion on whether health care is a right. Opponents of the concept of health care as a right claim that health care is like a house, a car, or a college education. Like any other commodity in a free market society health care cannot be guaranteed. Proponents on the other hand say that health care is too important to be denied to all citizens. As medical diagnosis and treatment have become more sophisticated, life itself is prolonged and its quality improved. The discussion has taken on new life because more and more Americans are without health insurance.

A recent article by Steven Schroeder, President of the Robert Woods Johnson Foundation (*New Eng. J. of Med.* April 25, 1996) points out that there are presently 42 million Americans without health insurance, about one-sixth of the U.S. population. In Missouri there are currently 630,000 uninsured or about 14% of the children and adults under 65 years of age. If current trends continue, by the year 2002 the number of uninsured in the U.S. will jump to between 59 and 66 million, or between one-fifth and one-fourth of the population. These figures are based on the reasonable assumption that current Medicaid state enrollments will be frozen at their present levels and that employment sponsored insurance will continue to decline. In addition there are an estimated 29 million people underinsured for catastrophic illness.

The United States is the only major industrialized nation which does not have universal health insurance. The U.S. is also the only developed country which links health insurance to employment.

Critics of these statistics contend that the uninsured are mainly entry level young healthy individuals, workers between jobs, or the poor who will now be covered by Medicaid managed care programs. Schroeder refutes these notions by citing statistics showing that while the uninsured are on average poorer, they are otherwise demographically similar to the general population. One third of the uninsured make over $30,000 per year. Most of the uninsured are in families where at least one family member works. Medicaid enrollment will probably not compensate for the loss of employment based insurance as it has in recent years. Anticipated Congressional constraints will slow the expansion of Medicaid enrollees and, according to Schroeder, may even reverse Medicaid growth altogether.

Physicians should not be surprised by these statistics. Most of us have noted the increase in the number of uninsured patients who come to our offices. We treated many of these patients before they lost their jobs due to corporate downsizing, layoffs, or forced early retirement. The 55 to 65 year olds are particularly hard hit because of their vulnerability to cancer and vascular disease. After toiling in the workplace for 25 to 30 years, their lifetime savings can easily be wiped out by one serious illness.

As a result of this deplorable state of affairs the American College of Physicians (ACP) recently came out in support of a universal health care system. The ACP does not state what form the universal health care system should take. The AMA supports a "pluralistic approach to universal health coverage and access to health care services" (policy 165.920). Policy 160.998 states that "the medical profession will see to it that every person receives the best available medical care regardless of his or her ability to pay." Policy 2.095 states that "society has an obligation to make access to an adequate level of health care available to all of its members regardless of ability to pay." Neither policy states how the goals of assuring adequate health care for every person in society is to be achieved.

The United States is the only major industrialized nation which does not have universal health insurance. The U.S. is also the only developed country which links health insurance to employment. This linkage came about fortuitously not by plan. During the War World II era there were wage-price controls which prevented employers from giving their employees raises. Instead they gave them tax-free health benefits. The health benefits were supposed to be temporary. But employees and unions liked them so much that they became permanent. What worked 50 years ago when health care costs were minimal is clearly not working now.

What is the solution to the problem of uninsured? Presently politicians choose to ignore the problem probably because of cost considerations. But as the number of uninsured grows, the problem won't go away. Since the Clinton health reform debacle three years ago – which for all its faults did address universal coverage – universal health insurance has not been on the politician's agenda. Today the political agenda has two goals: 1) controlling runaway health care costs, and 2) incremental health system reform.

Policy makers of all political stripes view managed care as the means of controlling runaway health care costs. The jury is still out on whether managed care can lower costs significantly in populations which include an entire community – sick as well as healthy persons. What is irrefutable, is that despite the increased penetration of managed care in the marketplace the number of uninsured is going up. According to the Urban Institute, 12.6 million people or nearly 9% of the nonelderly population lost employer-sponsored health coverage between 1988 and 1993. The obvious question is if managed care is so successful in lowering health care costs why are more and more employers dropping health care coverage for their employees. It is evident that if present trends continue, and all indicators are that they will, managed care is not going to solve the problem of the uninsured or universal health coverage and access for all Americans.

It is evident that if present trends continue, and all indicators are that they will, managed care is not going to solve the problem of the uninsured or universal health coverage and access for all Americans.

The Kennedy Kassebaum bill is an example of incremental health system reform. Its major goals are portability of insurance and no exclusion for preexisting illness. It passed the U.S. Senate 100 to 0. In my opinion its passage is largely symbolic because insurance companies will still be free to charge whatever they please. Premiums will be so high for patients with preexisting illnesses that policies will not be affordable. In the state of Washington a bill similar to Kennedy Kassebaum has been enacted. As reported by the *Wall Street Journal* recently, the law has produced serious financial problems for the state and private insurance companies because of the large number of persons now being treated with serious costly chronic illnesses such as AIDS.

Opponents of insurance reform bills such as the Health Insurance Association of America cite the Washington state experience as confirming their gloomiest predictions. The proponents of insurance reform bills like Kennedy-Kassebaum say that the problem is lack of community rating and failure to spread the insurance risk to the entire population of the state. The culprit, they contend, is not the insurance reform plan but ERISA, the law which covers companies which self insure their employees. Under this law the employees of self insured corporations who are healthier than the general population are excluded from the state plan. Between 60 and 65% of the working population of the U.S. is insured under ERISA plans.

The solution to the problem of the uninsured may be similar to the Republican and Democratic plans for Medicare. Citizens would be allowed to choose a plan from menus. The menus contain choices such as HMOs, PPOs, traditional fee for service, and possibly medical savings accounts. Such a program would be similar to the present Federal Employee Health Benefit Plan (FEHBP). The FEHBP has the advantage of preserving freedom of choice of physician and health plan. It has not, however, been shown to reduce costs significantly.

If none of the present plans is successful in stemming the tide of the expanding population of the uninsured tremendous political pressure will build up. Our present archaic and dysfunctional employment based health insurance system might implode, and we could end up with a single payer system. MoMed

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Trends in Reported *Campylobacter, Salmonella* and *Shigella* Infections, Kansas City, Missouri

Gerald L. Hoff, PhD, FACE, Wusan Chen, MB, MPH, Andrew A. Warlen, BS
and Dale H. Giedinghagen, MS

An epidemiologic analysis of *Campylobacter, Salmonella* and *Shigella* morbidity among Kansas City, MO, residents was conducted for the period 1980-1994. *Campylobacter* and *Shigella* exhibited increasing trends in incidence while *Salmonella* declined. Morbidity peaked during the summer for each organism. Non-white non-black residents had the highest disease incidences for all three bacteria as did children < 4 years of age. There were 7 outbreaks of *Salmonella* or *Shigella*.

An essential function of public health is epidemiologic surveillance for infectious diseases and other conditions.[1] This surveillance function generally is formalized in state law or local ordinance and requires health care providers, diagnostic laboratories, and others to make reports in a timely fashion to their local health department. Unless there is adequate funding and personnel in the health department, the surveillance function is essentially a passive mechanism that relies upon the reporting source to initiate the notification process. Consequently, most epidemiologic surveillance in the nation and in Missouri is of a passive nature and there is considerable variability in the percent of infections reported, varying from locality to locality and over time for any particular disease.[2 3]

Infectious disease surveillance in Kansas City is a passive system and, irrespective of its limitations, morbidity data gathered over time can provide insights into the epidemiology of various diseases. This report analyzes reported infections of *Campylobacter, Salmonella* and *Shigella* among Kansas City residents during the years 1980 through 1994. Both *Salmonella* and *Shigella* were reportable disease conditions throughout this 15-year period, and *Campylobacter* became reportable in 1984.

Methods

Morbidity reports pertaining to *Campylobacter, Salmonella,* and *Shigella* were received by the Disease Control Program from health care providers, hospital infection control nurses, diagnostic laboratories, and other sources. Each report was investigated to the extent practical and necessary to verify the diagnosis, identify any related cases, and, if possible, determine the source of infection. Cultures of contacts to a reported case were not collected with the exception of outbreak and typhoid investigations. Relevant control procedures were initiated as needed. An outbreak of any of the three bacteria was considered as two or more non-familial cases.

The data were entered into the dBASE® morbidity register maintained by the Kansas City Health Department's Disease Control Program. Additional information for this report was obtained from outbreak investigation reports and the individual files of typhoid cases. For each of the three diseases included in this report, a descriptive epidemiologic analysis of cases among Kansas City residents was completed. The rates used in calculating trend information were based on the U.S. Census Bureau figures for 1980, 1990, and 1995, with interpolation of population levels for the intervening years. The age- and race/ethnicity-specific rates were calculated on the basis of the 1990 census. Statistical analysis was done using the Chi square test at the P .05 significance level.

The trend data from 1980 through 1994 were used to produce 1995 morbidity forecasts for each of the enteric bacteria using the FORECAST PRO software program (Business FORECAST

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Systems, Inc., Belmont, MA). Two forecasting methods were used - exponential smoothing when using 15-year or 10-year trend data and simple moving average when using the 5-year trend information. These methods were automatically selected by the software program.

Table 1. Reported Cases and Annualized Incidence Rates for *Campylobacter*, *Salmonella* and *Shigella* among Kansas City, MO, Residents, 1980-1994

	Campylobacter N = 465	*Salmonella* N = 675	*Shigella* N = 851	Total N = 1,991
Rates/100,000 population by 5 y intervals				
1980-1984	3.2[1]	10.3	6.7	19.5
1985-1989	8.2	11.0	11.1	25.7
1990-1994	10.3	9.2	21.0	31.0
Racial/ethnic rates/ 10,000 population				
White	0.6	0.7	0.5	1.9
Black	0.4	1.6	1.3	4.9
Other	3.4	1.8	2.3	7.5

[1] Data is for 1981-1984 only; first reported case was in 1981.

Table 2. Predictions of 1995 mobidity based on 1980-1994 trend data for *Campylobacter, Salmonella* and *Shigella,* Kansas City, MO.

Length of trend series	*Campylobacter*	*Salmonella*	*Shigella*
15 years[1]	38[2] (16-60)	44 (27-60)	85 (14-155)
10 years	39 (18-60)	43 (23-63)	85 (2-167)
5 years	48 (18-78)	38 (24-53)	97 (38-156)
1995 Cases, actual	45	39	125

[1] *Campylobacter* based on a 14-year trend.

[2] Forcasted incidence and 95% confidence limits.

Results

Trends

From 1980 through 1994, there were 1,991 reports of *Campylobacter* (N=465), *Salmonella* (N=675) and *Shigella* (N=851) infection among residents of Kansas City (Table 1). Although *Campylobacter* officially became a reportable infection in 1984, the Health Department began receiving case reports in 1981. The incidence of reported cases slowly increased as hospital laboratories began to incorporate testing for this organism into their routine enteric bacteria workup. Between 1986 and 1990, the annual average number of reported cases of *Campylobacter* was 36, rising to 48 between 1991 and 1994 (Fig. 1). The annual incidence of *Salmonella* was fairly constant, averaging 45 cases per year with a range of 32 to 66 cases per year, while that of *Shigella* was quite volatile, ranging from 7 (in 1982 and 1987) to over 110 cases per year (113 in 1989 and 132 in 1992). The average yearly incidence for *Shigella* was 31 cases from 1980 through 1988, however from 1989 through 1994, this rose to 96 cases per year. Seasonally, infections for the three bacteria peaked during the summer months, although the individual peaks were staggered with *Campylobacter* in June, *Salmonella* in September and *Shigella* in August (Fig. 2).

Of the three morbidity forecasts generated for each bacterium, the simple moving average FORECAST based on the most recent 5-year trend yielded the closest prediction, although the actual 1995 case counts fell within the confidence limits generated using trend data of any length (Table 2). The volatile nature of *Shigella* morbidity on a year to year basis is reflected in the discrepancy between the morbidity FORECAST value and its 95% confidence limits and the actual case count.

Of the 675 reported *Salmonella* cases, the bacteria was recovered from blood cultures of 56 (8%) individuals. Among those persons with bacteremia, only two individuals were co-infected with the human immunodeficiency virus. There were two instances in which siblings were diagnosed as bacteremic for *Salmonella*. The first pair, in 1981, involved an 11-year-old girl and her 14-year-old brother who were diagnosed four days apart. The second pair, in 1982, involved a set of 4-month-old fraternal twins who were diagnosed three weeks apart.

Table 3. Most Commonly Reported *Salmonella* Serotypes, Kansas City, MO, 1980-1994

Serotype	Frequency	% of Total Isolates (N = 324)
S. typhimurium	68	21.0
S. enteritidis	66	20.3
S. heidelberg	50	15.4
S. typhi	18	5.6
S. montevideo	13	4.0
S. hadar	11	3.4
S. infantis	9	2.8
S. agona	8	2.5
S. newport	8	2.5

Speciation

All of the isolates of *Campylobacter* were reported as *C. jejuni*. For *Salmonella*, Group B isolates were the most common representing nearly 42% of the total, followed by group D (18.7%), group G (18.2%), group C_1 (9.8%), group C_2 (7.7%), and group E (2.3%). Only 48% of the *Salmonella* isolates were reported beyond the group level and represented 41 different serotypes, with nine serotypes accounting for 77.5% of the total speciated (Table 3). Of the 851 *Shigella* isolates, 761 (89%) were speciated; 693 (91.1%) were *S. sonnei*, 62 (8.1%) *S. flexneri*, and 6 (0.8%) *S. boydii*.

Demographics

Persons in racial/ethnic groups other than white or black had the highest incidence rates for all three infections (Table 1). The incidence rate for *Campylobacter* among blacks was lower than that for whites, but for *Salmonella* and *Shigella* blacks had incidence rates 2.2-2.6 times that of whites. The incidence rates for persons who were neither white nor black were significantly higher than those of whites for all three infections and that of blacks for *Campylobacter* only. In turn, blacks had incidence rates for *Salmonella* and *Shigella* that were significantly higher than those of whites. There were no significant differences for any of the bacteria in the incidence rates between the sexes within the racial/ethnic groups. For all three infections, the age-specific incidence rates were highest for children < 4 years of age and declined sharply in persons ≥ 5 years of age (Fig. 3). While *Campylobacter* had the lowest inci-

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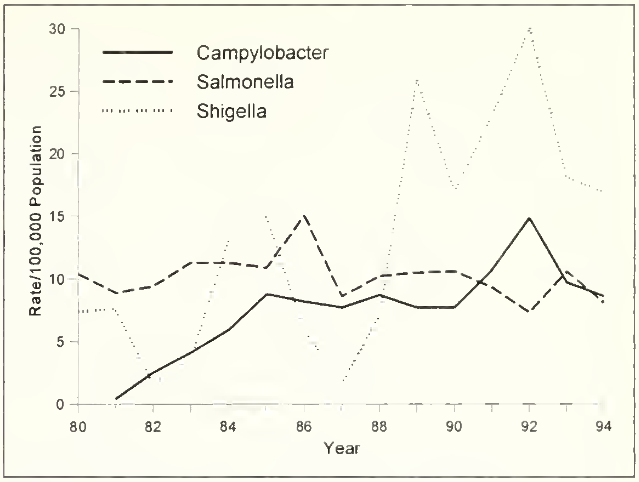

Figure 1. Incidence per 100,000 population of *Camplylobacter*, *Salmonella* and *Shigella* among Kansas City, MO, residents, 1980-1994.

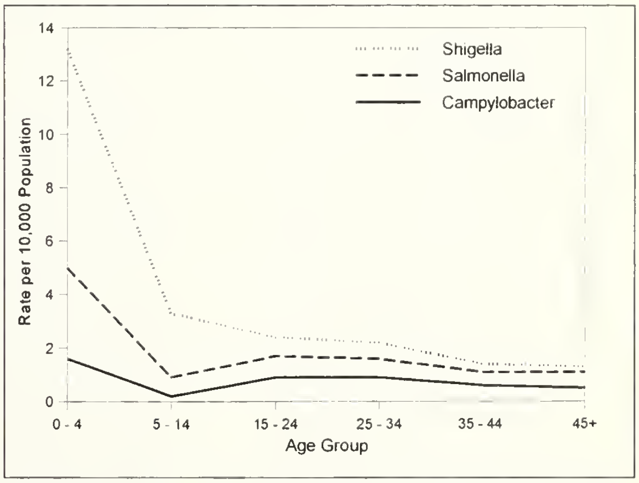

Figure 2. Annualized age-specific incidence rates for *Camplylobacter*, *Salmonella* and *Shigella* among Kansas City, MO, residents, 1980-1994.

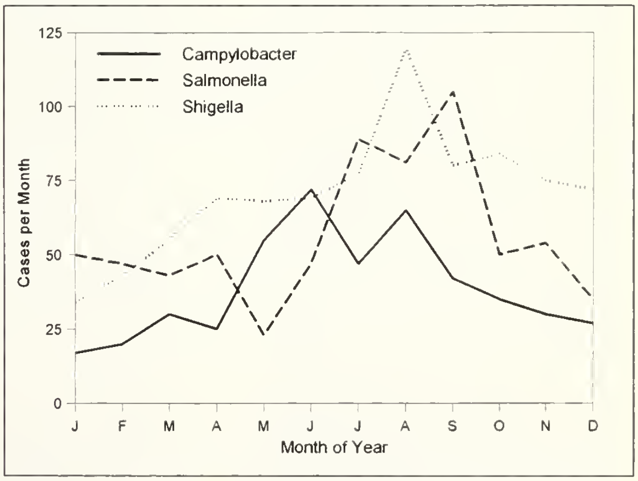

Figure 3. Seasonality of *Camplylobacter*, *Salmonella* and *Shigella* infections among Kansas City, MO, residents, 1980-1994.

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dence rates among children, it tended to be higher than those for *Salmonella* and *Shigella* in persons ≥ 15 years of age. The opposite was true for *Shigella* which had the highest incidence rates of the three infections among children, but the lowest among persons ≥ 15 years old. The age-specific incidence rates for *Salmonella* were intermediate for all age groups except those ≥ 45 years of age when it slightly exceeded that of *Campylobacter*.

Epidemiology

Multiple cases of infection within a family were not reported for *Campylobacter*. Ten cases (1.5%) of the 675 reported *Salmonella* infections occurred within families as five separate incidents. Two of these incidents involved *S. typhi*. Family clusters of *Shigella* were reported 39 times, involving 80 (9.4%) out of the 851 reported cases. In 36 incidents, the individuals who were infected were children ≤ 9 years of age, with 82% of the children being ≤ 5 years old. The remaining three incidents involved a parent and at least one child.

There were no outbreaks of *Campylobacter* reported in the community, but there were two of *Salmonella* and five of *Shigella*. One of the *Salmonella* outbreaks was nosocomial and occurred in a residential setting for developmentally disabled patients during July and August 1981. Of 14 suspect cases only two were confirmed by culture yielding *Salmonella* group B; no source was identified. The other outbreak involved six cases of *S. manhattan* during August and September of 1988. These cases were associated with a restaurant that specialized in Mexican food. No source was identified although one food handler was found to be infected with *Shigella*.

All five *Shigella* outbreaks occurred between 1989 and 1994. The first occurred in May 1989 and involved 50 presumptive cases who ate from a salad bar in a restaurant.[4] Ten out 13 cases were confirmed bacteriologically as *S. sonnei*. One of 39 employees also was infected, but denied illness. There were two secondary cases related to this outbreak. The employee who was infected was responsible for the preparation and setup of the salad bar.

Two outbreaks involved the same day care center. The first outbreak was in May and June 1991 and the other between May and July 1993. In the 1991 outbreak, the index case had been symptomatic for 22 days, but had not received medical evaluation nor had he been excluded from day care. An additional seven cases among the enrollees were identified. The 1993 outbreak involved five children and one family contact. The first two cases were foster brothers. They and their foster mother all were infected with *S. flexneri*. Three additional children who were the same age as the index case subsequently became ill and were diagnosed as having *S. sonnei*. Isolates were not available to determine whether misidentification had occurred or if these were two unrelated events, that is, a family outbreak and a day care center outbreak.

The remaining outbreaks also involved day care centers. One was in August and September 1993. There were three cases in the day care center and four among family contacts. The putative index case was the director of the day care center who apparently became ill while traveling in the Springfield, Missouri, area and who was not reported by her physician. Two children in the center subsequently became ill and infected members of their respective families. All isolates were *S. sonnei*.

The fifth outbreak was in December 1994 and involved seven confirmed and six suspect cases of *S. sonnei* in four families. Four of the confirmed and one of the suspect cases were enrollees at the same day care center. The remaining cases were family contacts. Numerous hygienic deficiencies were noted within the day care center.

Typhoid

Between 1980 and 1994, there were 18 cases of *S. typhi* diagnosed among City residents. All but one of these infections were diagnosed between 1980 and 1987. The exception was a five year old girl diagnosed in 1994; all locating information for this individual was false and the case could not be investigated further. Of the 17 other cases, one case could be attributed to travel to India. Four cases were elderly individuals, one of whom was a Southeast Asian immigrant, born between 1895 and 1909. Based on histories, the one man and three women were considered to be lifetime carriers. One of these women infected her 1-year-old granddaughter. There were two other instances of transmission from a carrier to a child. One involved a

33-year-old woman who was a carrier and her 10-year-old daughter. The other was a 1-year-old child who was believed to have been infected her grandfather who resided in Texas and who was a carrier. Two cases in 1980 were part of a typhoid outbreak associated with a wedding in Greenfield, Missouri. And, four unrelated cases involved adults 18 to 59 years of age for whom no sources of infection were identified.

Discussion

It has been reported that *Campylobacter* is more commonly isolated from fecal specimens of diarrheal patients than either *Salmonella* or *Shigella*.[5] Yet, since 1982 when the Centers for Disease Control and Prevention initiated its surveillance for *Campylobacter*, the national isolation rate remained steady at 5 to 6 per 100,000 population.[6] This was considerably below the average annual incidence of 18.8 cases per 100,000 for nontyphoidal *Salmonella* and 9.4 for *Shigella* over the 1980-1994 time period.[7]

In Kansas City, the average annual incidence rate of *Campylobacter* for 1981-1994 was 7.2 per 100,000. However, if only the most recent five years are considered then the average incidence rate for *Campylobacter* was 10.3, higher than the 9.2 for *Salmonella* but less than the 21.0 for *Shigella*. For Missouri, the annual incidence rate for *Campylobacter* between 1990-1994 was 11.4, exceeding that of *Salmonella* (11.1) and *Shigella* (9.9).[8] Clearly, *Campylobacter* infections are increasing in importance in both Missouri and Kansas City.

The observed age-specific incidence for *Campylobacter* in Kansas City was reflective of that reported nationally, with the highest incidence in infancy and then peaking again in young adulthood.[9] [10] The lack of community outbreaks related to campylobacteriosis was not unexpected, as community outbreaks usually are associated with gross contamination of food or water. In fact, most human infections probably result from eating contaminated food, particularly undercooked poultry which is estimated to be responsible for 50% to 70% of sporadic *Campylobacter* infections.[11] An infectious dose of this organism is substantially higher than that for *Shigella* [12] and person-to-person transmission plays only a minor role in disease transmission. In addition, transmission by asymptomatic excreters who are food handlers or health care workers has not been reported.[6]

Nationwide, in Missouri, and in Kansas City, the average annual incidence rate of nontyphoidal *Salmonella* infection per 100,000 persons declined slightly during the period 1990-1994, compared to the time period 1980-1989. At the same time, the average annual incidence rates for *Shigella* increased. In Kansas City, both *Campylobacter* and *Shigella* infections were reported more often, while statewide, the average incidence rate for *Salmonella* was slightly below that of *Campylobacter* and 12% higher than that of *Shigella*. The declining trend in the average annual incidence rate for *Salmonella* was in stark contrast with that observed nationally during the 1980s when the incidence of *Salmonella* was increasing, while that of *Shigella* was not.[13]

In Kansas City, symptomatic *Salmonella* infections essentially were sporadic events and outbreaks were uncommon. However, recognition of outbreaks may have been hampered by the low rate of species identification. Only 48% of isolates were speciated. Community outbreaks easily can be missed when most cases are reported as sporadic incidents and so few of the isolates are speciated. The 1988 outbreak of *S. manhattan* illustrates this point. Prior to 1988, only one case of infection had been attributed to this serotype. Hence, when six supposedly unrelated cases began to be reported in the summer of 1988, it was apparent that an outbreak had occurred and a probable common source was identified. While it may make little difference to the clinician treating the patient with salmonellosis which serotype was involved, it is important to know for public health reasons. For example, there is growing rebirth in recognition in the United States of the role of reptiles, particularly iguanas, in human salmonellosis. During 1993, 4% of cases in the State of New York reported contact with a reptile before coming ill.[14] *Salmonella* carriage by reptiles is not uncommon[15] and this was the disease that resulted in the ban on the sale of baby pet turtles.[16] In Missouri and other places, for example, *S. poona* frequently has been associated with human infections acquired from iguanas.[17]

Between 1980 and 1994, the number of typhoid fever cases

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reported in the United States fluctuated between 350 and 550 per year. In Kansas City, there were 18 cases of *S. typhi* over the 15-year period; only one was reported after 1987. And, although cases were reported each year, in Missouri the reported number of cases declined from a high of 20 in 1980 to 1 in 1994. While the trend for typhoid fever on the national level has been stable, or declining slightly, in Missouri and Kansas City typhoid certainly has become an uncommon event.

The variability in annual number of reported *Shigella* cases in Kansas City was striking with sharp increases at 3- to 4-year intervals. The overall trend has been towards an increasing average annual incidence. Cases peak in August, a month when many children begin or return to day care. A similar observation regarding the start of the school year has been reported from Great Britain.[18] With its low infectious doses, as few as 10 organisms, transmission of the bacteria via hands is a common means of acquiring infection, thus facilitating outbreaks in situations such as day care centers. And secondary cases of shigellosis during outbreaks are common. Thus it is difficult to understand why, in Kansas City, only four outbreaks involving day care centers were recognized and all between 1991 and 1994. However, the ease of transmission does explain why nearly 10% of cases occurred within families.

In 1985, men aged 20-49 years of age accounted for 23% of all *S. flexneri* cases in the United States and increased male homosexual transmission was hypothesized a possible explanation.[19] Only 4% of cases in Kansas City were men in this age group and there was no evidence that homosexual transmission was a significant factor in maintaining this *Shigella* serotype in the community.

In summary, *Campylobacter* and *Shigella* are increasingly recognized infections in Kansas City, while morbidity attributed to *Salmonella* is declining. Only recently have community outbreaks of *Shigella* in Kansas City been recognized, primarily in day care centers. The scarcity of outbreaks related to *Salmonella* partially may be attributed to low percentage of isolates speciated. Whether this contributes to the very low incidence of reported typhoid is unknown.

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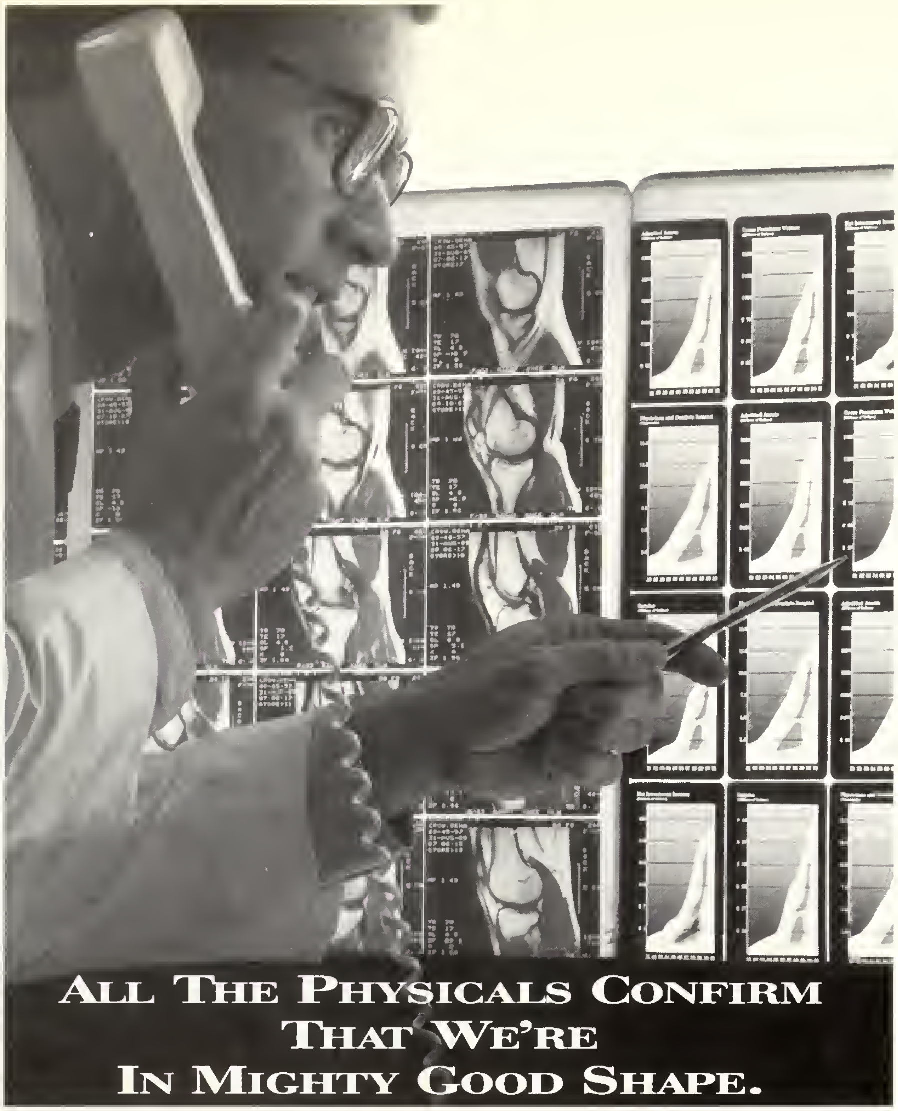

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Pancytopenia Due to Vitamin B12 Deficiency Associated With Graves' Disease

Richard W. Burns, MD and Thomas W. Burns, MD

Pancytopenia has a broad differential diagnosis, which can be narrowed depending on the cellularity of the bone marrow. The authors describe a complex patient with a history of Graves' disease who presented with pancytopenia, initially suspected of being due to aplastic anemia. He was later diagnosed with Vitamin B12 deficiency as a result of pernicious anemia. The potentially striking hematologic effects of cobalamin deficiency and the autoimmune basis for concurrent Graves' disease and pernicious anemia are reviewed.

Vitamin B12 deficiency is not an uncommon occurrence in the United States, occurring in 3 to 10% of patients over age 65.[1,2] The diagnosis can be relatively easy to make in florid cases, with features involving hematopoiesis, the gastrointestinal tract, and the nervous system. Classic hematologic changes of vitamin B12 or cobalamin deficiency include macrocytosis and hypersegmented neutrophils seen on a blood smear. Pancytopenia can also occur with this disorder. The authors describe a 46-year-old man with a history of Graves' disease who presented with pancytopenia, which was initially suspected to be secondary to drug-induced aplastic anemia. Vitamin B12 deficiency secondary to pernicious anemia was subsequently found to be the cause of his red blood cell, white blood cell, and platelet reduction. Although vitamin B12 deficiency is part of the differential diagnosis of pancytopenia, it is less frequently considered than other disease entities, such as aplastic anemia. The mechanism for pancytopenia in patients with cobalamin deficiency, and the association of Graves' disease with pernicious anemia, are discussed.

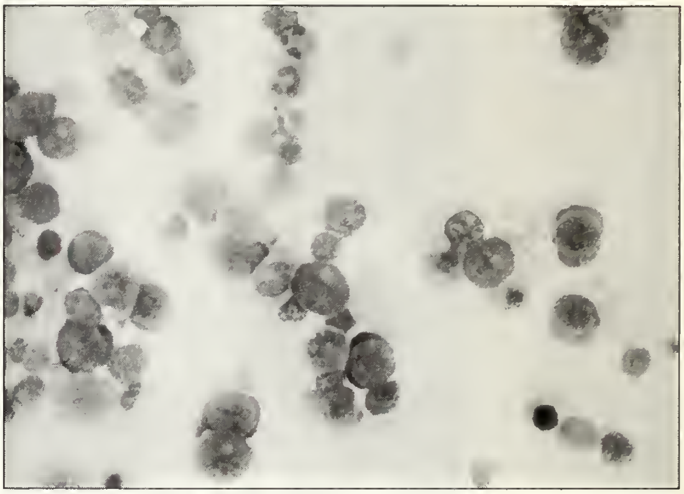

Figure 1. Bone Marrow Aspirate.

Case Report

A 46-year-old man was admitted to the University of Missouri Health Sciences Center on 9/25/95. Three days earlier he had presented to the Endocrine Clinic with a myriad of complaints including weakness, malaise, dyspnea, and chest discomfort. A heme profile revealed pancytopenia with a hemoglobin of 7.7 g/dl, white blood cell count 3.7 thou/cu mm, and a platelet count of 80 thou/cu mm (see Table 1).

The patient's past medical history was remarkable for Graves' disease diagnosed in 1991. He had been treated with propylthiouracil (PTU) but was poorly compliant with this medication. His occupation demanded a high energy level, which he discovered was more sustainable if PTU was decreased or withheld. He had been offered treatment with radioactive iodine ablation but refused. A heme profile in June of 1994 was normal.

The patient's vital signs on admission were normal except for a slight fever of 38.1°C. He weighed 123 kg and had a slightly icteric skin color, but otherwise appeared well. The thyroid gland was not palpable and there were no other manifestations of Graves' disease including eye involvement. The liver and spleen were not palpable. Examination of the lower extremities revealed 3 to 4+ pitting edema in the pre-tibial areas bilaterally, with slight skin hyperpigmentation of the feet and ankles. Neurological examination was remarkable for diminished vibratory perception in both lower extremities. The remainder of his examination was normal.

Admission laboratory tests included the following: Heme profile and thyroid function tests are listed in Tables 1 and 2 respectively. Serum total bilirubin was 1.9 mg/dl, indirect bilirubin 1.1 mg/dl, and a lactate dehydrogenase level was 687 U/L. Other liver function tests and electrolytes were normal. Red cell indices were as listed in Table 1. Red cell morphology was remarkable for the presence of anisocytosis, poikilocytosis, macro-ovalocytes, few target cells, occasional shistocytes, and few microcytes. Occasional hypersegmented neutrophils and large platelets were also seen. The reticulocyte count was 3.5 %, and reticulocyte index was 0.6.

Because of the rare but documented association between PTU and aplastic anemia,[3] the drug was discontinued. Although hemodynamically stable, the patient was given two units of packed red blood cells two days following admission when a fall in hemoglobin to 6.6 g/dl was noted. Prior to transfusion, a bone marrow biopsy and aspirate were obtained. The biopsy revealed hypercellularity, with marked increase in immature erythropoietic elements, and myeloid cell lines exhibiting megaloblastic changes (Fig 1). The patient was subsequently discharged 9/29/95 after his heme profile stabilized and aplastic anemia was excluded as cause for his pancytopenia.

Following discharge, the patient's serum B12 level was reported as severely deficient, 32 pg/ml (reference range 200 - 1200 pg/ml); the B12 content of an earlier serum sample was measured and found to be low, 51 pg/ml. An RBC folate level was normal, 144 ng/ml (reference range 125 ng/ml or more). The patient received 1000 mcg of intramuscular B12 on 10/04/95, and was scheduled for a Schilling test. Both parts I and II were

Continued on page 370

Table 1. Heme Profile Data*

	6-29-94	9-22-95	10-4-95	10-11-95	11-30-95
White Blood Cells (thou/cu mm)	8.1	3.7	1.9	2.8	6.2
Red Blood Cells (mil/cu mm)	4.21	1.98	1.91	2.92	4.98
Hemoglobin (g/dL)	13.5	7.7	6.9	9.8	14.3
Platelets (thou/cu mm)	139	80	40	148	169
Reticulocyte Count (%)	---	3.5	0.2	8.8	---
Mean Cell Volume (fl)	95.1	112.6	---	---	87.0

*Reference Range: White Blood Cells (4.5 - 11.0 thou/cu mm). Red Blood Cells (4.60 - 6.20 mil/cu mm). Hemoglobin (13.5 - 18.0 g/dl). Platelets (150 - 400 thou/cu mm). Reticulocyte Count (.5 - 1.5 %). Mean Cell Volume (80 - 96 fl).

Table 2. Thyroid Function Tests*

	6-29-94	9-22-95	10-4-95	10-11-95	11-30-95
Thyroxine (mg/dL)	20.5	20.7	---	31.5	10.5
Thyroid Stimulating Hormone (mIU/L)	0.06	<0.03	---	<0.03	---

*Reference Range: Thyroxine (5.0 - 12.0 mg/dL).
Thyroid Stimulation Hormone (0.32 - 5.0 mIU/L).

Table 3. Schilling Test Data *

	Schilling I	Schilling II
Urine Volume	1675 ml	1625 ml
CO-57 B12 Excretion	2.74%	5.61%
Impression:	Decreased Intestinal Absorption of Vitamin B12	Significant Improvement of Vitamin B12 Absorption with Intrinsic Factor

*Reference Range: CO-57 B12 Excretion 7.0 % or greater.

Table 4. Differential Diagnosis of Pancytopenia*

Decreased production of mature hematopoietic cells

Normal or increased bone marrow cellularity, but ineffective hematopoiesis
  - Myelodysplasia
  - Severe folic acid deficiency
  - Severe vitamin B12 deficiency
  - HIV infection

Decreased bone marrow cellularity
  - Hematopoietic failure/bone marrow failure/aplastic anemia
  - Myelodysplasia
  - Myelofibrosis
  - Hairy cell leukemia
  - Paroxysmal nocturnal hemoglobinuria
  - Acute leukemia
  - Infiltration of bone marrow by extrinsic neoplastic cells
  - Granulomatous infiltration
  - Sepsis
  - Anorexia Nervosa/malnutrition
  - HIV infection

Increased destruction or sequestration of mature hematopoietic cells

  - Hypersplenism
  - Hairy cell leukemia
  - Myeloid metaplasia with myelofibrosis
  - Immune (antibody-mediated) pancytopenia
  - Paroxysmal nocturnal hemoglobinuria
  - Sepsis
  - HIV infection

*MKSAP 10, Hematology, 1995 by the American College of Physicians.

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consistent with a diagnosis of pernicious anemia (see Table 3). Serum was tested for intrinsic factor antibody, which was present by immunoassay method, and a serum gastrin level was markedly elevated, 1196 pg/ml (reference range 0 - 100 pg/ml).

Two months following B12 treatment, the patient's heme profile showed a normal white blood cell count, hemoglobin, and platelet count. The patient also consented to treatment of his Graves' Disease with radioactive iodine and was given 12.9 mCi of Iodine-131 on 10/27/95. Six weeks later, the patient's serum thyroxine was 10.5 ug/dL. On 01/23/96 his serum free T4 was 2.08 ng/dL and his serum thyroid stimulation hormone was less than 0.03 mIU/L, values consistent with persistent hyperthyroidism. At his most recent visit, 5/06/96, the patient complained of being "wired," comparable to the feelings he experienced when hyperthyroid in the past. His free T4 was 4.04 ng/dL and his TSH less than 0.03 mIU/L. His projected management includes repeat treatment with radioactive iodine, monthly B12 injections and periodic hema-tologic and thyroid assessment.

Discussion

Pancytopenia, defined as reduction in the number of erythrocytes, white blood cells, and platelets in the blood, can be viewed as occurring by two different mechanisms: decreased production of hematopoietic cells with either normal or decreased bone marrow cellularity, or increased destruction or sequestration of hematopoietic cells. Aplastic anemia is a classic example of diminished blood cell production with bone marrow hypocellularity, and commonly is at the forefront of consideration when pancytopenia is encountered. For some physicians these two terms are often erroneously considered synonymous. However, a wide variety of conditions can also cause pancytopenia, including vitamin B12 deficiency (Table 4). Unlike aplastic anemia, vitamin B12 or cobalamin deficiency is associated with a normal or increased bone marrow cellularity.

Vitamin B12 deficiency is probably best known as a cause of macrocytic anemia and neurologic symptoms, rather than other hematologic abnormalities including pancytopenia. Numerically, the red cells are the most consistently and severely depressed cell line in megaloblastic anemia, a descriptive term that refers to the abnormal changes in blood cell formation because of a single or combined deficiency of folate or vitamin B12. The mechanism for anemia in a patient with severe B12 deficiency is also responsible for the neutropenia and thrombocytopenia that can occur, and is denoted as ineffective erythropoiesis: ineffective hematopoiesis is a more accurate term since all cell lines are adversely affected. Vitamin B12 is required for two enzymatic reactions: 1) methylmalonate-succinate isomerization, necessary for synthesis of myelin in the central nervous system and 2) methylation of homocysteine to methionine, which ensures active DNA synthesis.[4] In B12 deficiency, this latter reaction results in aberrant DNA replication, and leads to abnormal red blood cell, white blood cell, and platelet precursors. These are eventually destroyed within the bone marrow, thus giving rise to the term ineffective hematopoiesis. The white blood cell count rarely falls below 2,000 thou/cu mm, and the platelet count is usually depressed in the range of 50 to 150 thou/cu mm, although in severe cases of cobalamin deficiency the reduction can be more striking.[5]

In addition to the quantitative depression of these cell lines, abnormal DNA synthesis also gives rise to the morphological abnormalities that are associated with vitamin B12 deficiency, seen both in the bone marrow and peripheral blood. The myeloid cells and megakaryocytes that do not suffer an intramedullary death are frequently misshapen because of the nuclear-cytoplasm maturation dissociation. The latter is responsible for the hypersegmented neutrophils and giant, bizarre platelets that are occasional seen on a peripheral blood smear of a patient with cobalamin deficiency.

The association between pernicious anemia and thyroid disease has been described for sixty years or more by a number of authors. In one large series of American patients with pernicious anemia, 48.3% had laboratory evidence of thyroid disease: Clinically, 11.7% were hypothyroid and 8.6% were hyperthyroid, while the other 28.0% had abnormal thyroid stimulation hormone (TSH) levels without clinical disease.[6] In another series of 410 patients with Graves' disease, 7 of these individuals later developed pernicious anemia.[7] Both disorders appear to share a common mechanism of disease: immunologic dysfunction with the development of autoantibodies and similar histologic characteristics on biopsy of thyroid and gastric mucosa.[8] In one collection of patients with pernicious anemia, 84 % had anti-parietal cell antibodies, 56 % had anti-intrinsic factor antibodies, and 55 % had anti-thyroid cytoplasm antibodies.[9] While it is clear that a family of immunoglobulins directed against the TSH receptor mediates thyroid stimulation in patients with Graves' disease, the basic cause of this disorder is unknown. In addition to autoantibodies, both pernicious anemia and another thyroid disorder, Hashimoto's thyroiditis, share similar histologic features of infiltrating plasma cells and lymphocytes, suggesting immunologic inflammation.[8] Disease of the thyroid and stomach mucosa may reflect the closeness of their embryologic origin, since both are derived from the foregut. In addition to thyroid disease, several other suspected autoimmune disorders also occur with greater than expected frequency with pernicious anemia; these include diabetes mellitus,[10]

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vitiligo,[12] Addison's disease,[10] idiopathic hypoparathyroidism,[11] and adult onset hypogammaglobulinemia.[13]

What are the clinical implications of the increased association of thyrotoxicosis and pernicious anemia? Some authors suggest laboratory testing for the latter disease plus other autoimmune syndromes in all patients with the diagnosis of Graves' disease.[14] At the current time a consensus opinion does not appear to exist. It would be prudent, however, to maintain a high level of suspicion for the co-existence of these two disorders, and order the appropriate follow-up studies when indicated. MoMed

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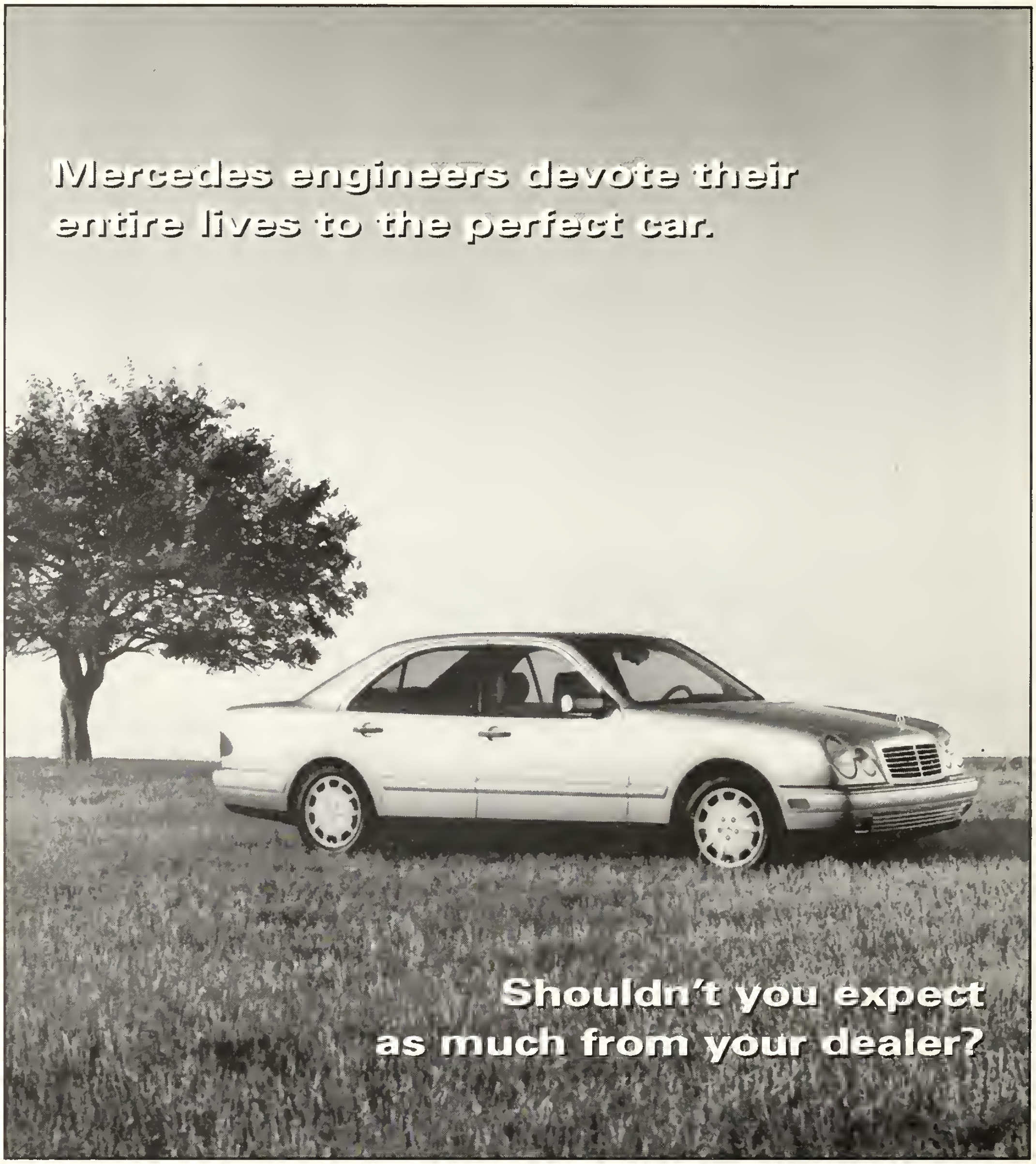
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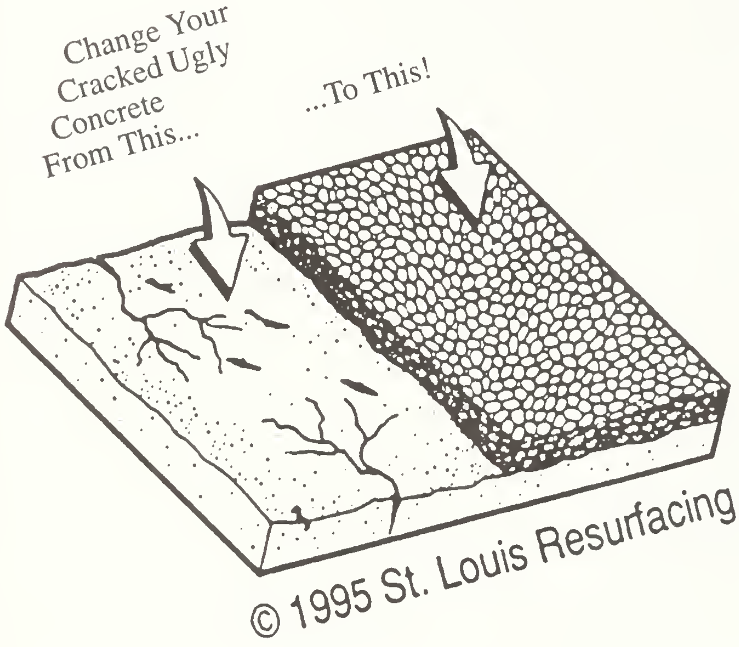
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VOLUME 93, NUMBER 8

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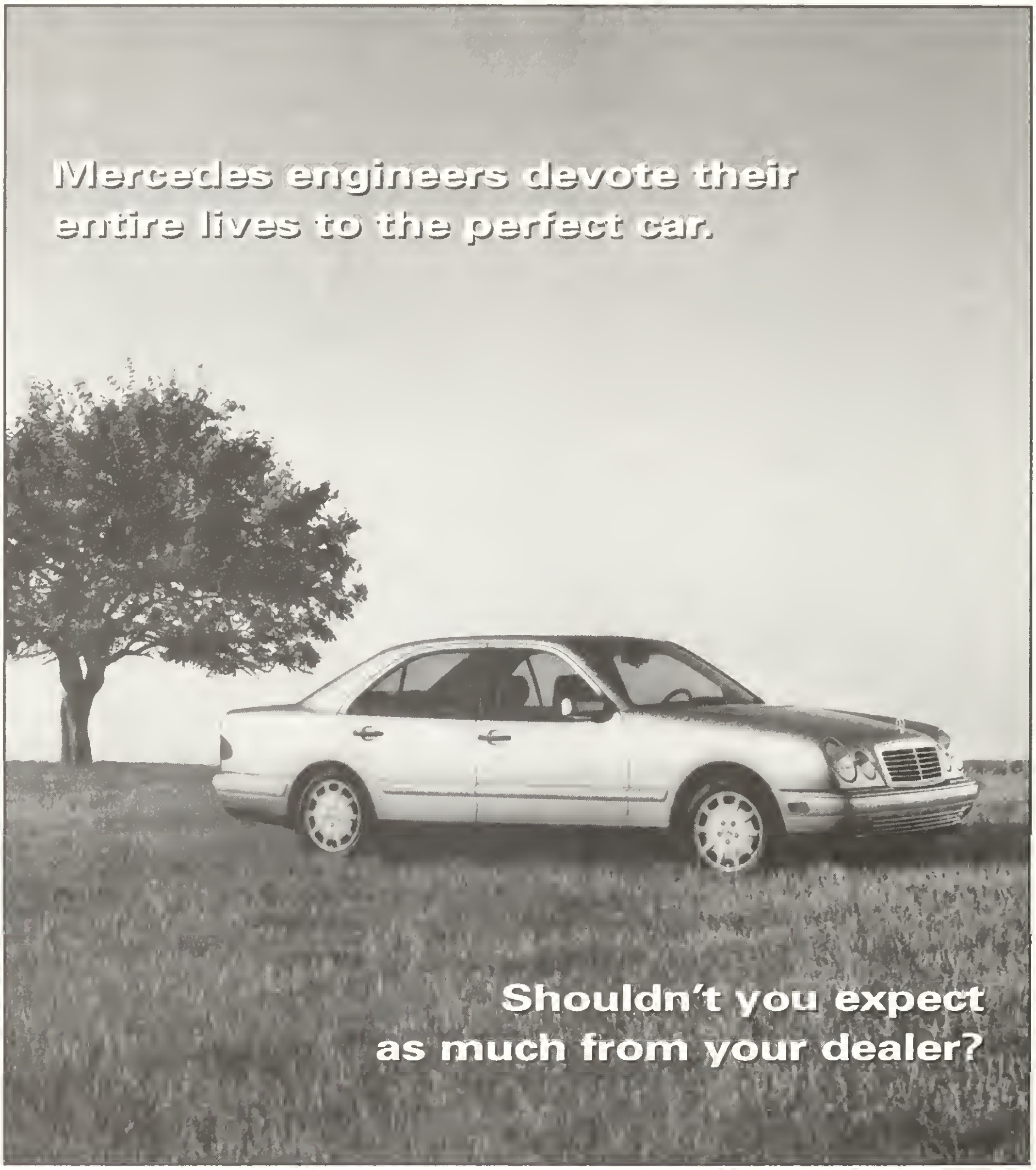

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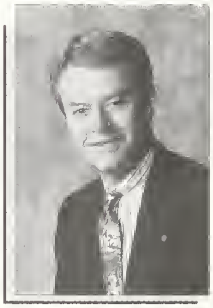

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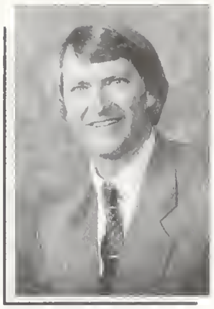

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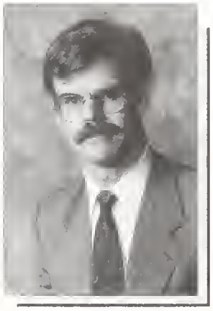

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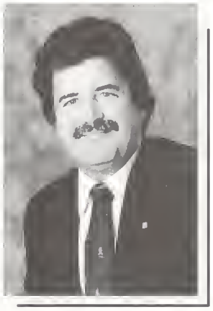

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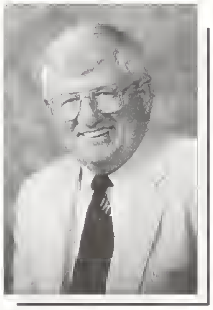

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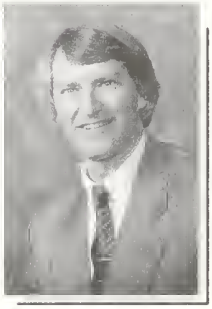

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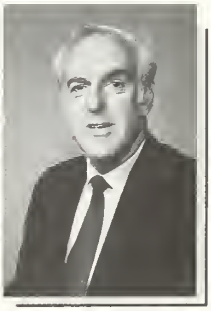

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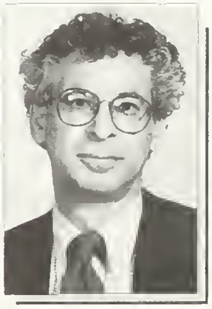

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MSMA Policies

Alcohol - Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA supports the Physicians' Health Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Alcohol - Driving

The MSMA encourages a zero tolerance law (defined as blood alcohol of 0.02% or greater) for drivers under 21 years of age. Violation of this law would result in suspension or revocation of driver's license. (1995)

Board of Healing Arts

The MSMA opposes any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good ethical and moral character. (1975)

The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Reporting of Cancer

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Collaborative Practice Guidelines

With the exception of extraordinary circumstances, the MSMA declares that a physician should not engage in a collaborative practice arrangement with more than two full-time equivalent advanced practice nurses and/or physician assistants at one time. Also a system of registration of all collaborative practice agreements, within sixty days of their execution, should be established. (1995)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

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Ordering of Diagnostic Tests

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Dioxin

The MSMA supports continuing monitoring of dioxin research, recognizing that to date no serious human disease has been conclusively linked to exposure to the chemical. The findings of the AMA Council on Scientific Affairs Panel on Toxic Substances are supported by the MSMA. (1985)

Disabled

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA works with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992)

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

(Drugs, Physician Dispensing)

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Drunken Driving

The MSMA supports the development of local task forces to study and remedy the problem of drunken driving. These task forces should include physicians, prosecutors, law enforcement officers, and legislators. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of prehospital (emergency) care by qualified physicians. (1986)

ERISA

The MSMA supports federal legislation that would modify ERISA to hold self-insured, employee health benefits plans accountable for negligent utilization review decisions and ensure meaningful remedies and fair compensation to patients who are injured as a result of such a decision.

MSMA is in support of federal legislation that is developed to modify ERISA from retroactively changing health care benefits, including monetary policy limitations, after an employee has already contracted an illness or condition.

MSMA advocates that these ERISA modifications be included in federal health system reform. (1994)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Expert Witness Qualifications

The MSMA supports legislation to formalize required qualifications for physicians wishing to testify as expert witnesses. (1992)

Fee-For-Service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fire-works in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

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Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

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Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance, Charge for Extra Claim Forms

Physicians should feel free to charge for the additional service of filing more than one insurance claims form for an individual patient, especially if different claim forms are required rather than a photocopy of the original form. (1973)

Insurance, Insurance Company Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of preexisting illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978); Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

International Medical Graduates

The MSMA Council and Committees are encouraged to consult with International Medical Graduate groups when subjects of interest come up. All physicians, international medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Laboratory, Collecting Fee

The MSMA supports payment under Medicaid to the physician for his or her service in collecting a specimen for tests performed in an outside laboratory. (1977)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Malpractice, Countersuits

Any Missouri physician found not to be negligent in a malpractice suit shall have the assistance of the MSMA in determining if there exists a reasonable basis for the physician to commence an action for malicious prosecution arising out of such case. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to mandatory assignment under Medicare. (1984)

The MSMA is opposed to the withholding of medical licensure based on the physician's nonacceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - DRGs for Physician Reimbursement

The MSMA opposes the use of Diagnosis-Related Groups as a system of reimbursing physicians under the Medicare program. (1992)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians. All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Third Party Reimbursement, Physicians

The MSMA supports equal reimbursement for equal professional services provided by a physician, regardless of his or her geographic location. (1982); Reaffirmed (1987)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988); Reaffirmed (1989)

Mentally Incompetent Patients, Hospitalization

The MSMA urges extension of the time limit from 7 to 21 days before the family of a mentally incompetent patient must petition the court for continuation of a hospitalization. (1985)

MSMF Loans

The Missouri State Medical Foundation requires membership in the Missouri State Medical Association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Nurse Practitioners

The MSMA supports the doctrine that physicians should retain control of medical care and will challenge any person who is practicing medicine without a license, in the courts of law if necessary. (1978)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Data

The MSMA asks that data from the Missouri Patient Care Review Foundation concerning decision-making criteria for Medicare admission be made available to Missouri physicians as a way to ensure that denials are not having a negative impact on the quality of medical care for these patients. (1985)

The MSMA supports the current AMA program of data collection on the costs of PRO implementation and the inequities in the PRO system. (1987)

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Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

PHO Open Enrollment

The MSMA supports open enrollment of qualified physicians in their hospitals' PHOs in order to preserve physicians' right to participate in any health care plan operating in Missouri. (1994)

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Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician Assistants

The MSMA opposes state licensure or certification of additional health care personnel because there is no reason to accept a second class or second level of medicine. (1979)

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Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient. (1981)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

Health Care Decision-Making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artificial hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-Making, Surrogate Decision-Maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him or her if he or she be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Tobacco

The MSMA supports all laws governing tobacco sales, which includes all tobacco products, and that the sale of single cigarettes, sales of cigarettes from vending machines, and tobacco billboard advertising be banned.

MSMA supports the current law whereby the use of tobacco products by minors is illegal and that providers and minors breaking this law should face a fine for both providers and minors, and a revocation of licenses. An increased excise tax and licensure fee should be designated to fund existing local enforcement agencies activities related only to tobacco regulations and local communities should be allowed to establish and enforce local tobacco regulations even if stricter than state regulations. (1995)

The MSMA supports legislation directed at designating nonsmoking areas in public places, and prohibits smoking at all MSMA House of Delegates meetings and scientific sessions held in conjunction with these meetings. (1981)

The MSMA actively supports legislation prohibiting cigarette smoking in public indoor areas. (1983)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

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Constitution & Bylaws

(adopted 1903, revised April 1996)

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, and the Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions & Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified for the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and hospital medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice-Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section and the Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice-Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been presented in the previous open meeting of the House of Delegates and that the amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physicians Section who are serving a full-time postgraduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine in a medical school approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Affiliate Members shall be those individuals who contribute to the health care of the public through employment service to MSMA members and component societies and who are not otherwise eligible for active membership. The criteria for affiliate membership and the policies governing the participation of affiliate members shall be established and maintained by the Council. Affiliate members shall have no voting rights nor will this class of membership apply toward House of Delegates or Council representation.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless that person is a member of the Missouri State Medical Association or sponsored by a member. In the latter situation, the paper would be considered that presented by a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the Association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegate's Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multi-county component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past-Presidents of the Association, the Speaker and Vice-Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to represent the Medical Student Section in the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physicians Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Organized Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Association.

Section 7. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as deemed necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 8. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 9. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 10. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 11. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 12. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of thirteen delegates, one from each Councilor District, one from the Medical Student Section, one from the Organized Medical Staff Section and one from the Resident Physicians Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he/she receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when that nominee shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice-Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilors and a Vice-Councilor for their district for a term of two years. The names of the elected Councilors and Vice-Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice-Councilor must reside or practice in the district for which that candidate is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physicians Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice-Councilor.

Section 6. Delegates from the Medical Student Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physicians Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Resident Physicians Section shall serve on an annual renewable basis.

Section 8. The Organized Medical Staff Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Organized Medical Staff Section shall serve on an annual renewable basis.

Section 9. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Section 10. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or a designated representative, shall preside at scientific sessions of the Association. The President shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. The President shall appoint all committees not otherwise provided for. The President shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. The President shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following the election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice-Presidents** shall assist the President in the discharge of presidential duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice-President. In the event of the death, resignation, or removal of the President, the First Vice-President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. The Treasurer shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice-President, the President and Treasurer, or the Treasurer and Executive Vice-President. The Treasurer shall subject the accounts to such examination as the House of Delegates may order, and shall annually render an account of treasury actions and of the state of the funds in his/her hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He/She shall be Secretary of the Council and shall keep a record of its proceedings. The Secretary shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his/her hands. The Secretary shall provide for the registration of the members and delegates at the Annual Convention. The Secretary shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each the status in relation to the practitioner's component society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. The Secretary shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. The Secretary shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. The Secretary shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as necessity may require, subject to the call of the Chair or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chair and a Vice-Chair for a term of one year. The Chair may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chair, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his/her district. The Councilor shall visit each county in the district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of the district. The Councilor shall make reports of the work and the condition of the profession of each county in that district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including the expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his/her term of office as Councilor, nor shall a Councilor vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 11. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chair of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice-President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until the successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice-President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the Chairs of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.
Young Physicians Committee

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, First Vice President, Secretary, Treasurer, Council Chair and Council Vice-Chair. The President of the Association shall be Chair of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice-President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, a successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chair of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, a successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of the respective medical society and geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

The **Young Physicians Committee** shall consist of members of the Association appointed by the President for a term of three years. The Young Physicians Committee shall act as a vehicle for increasing the involvement of young physicians in the membership activities of the Missouri State Medical Association.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose Chairs shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.
Commission on Medical Economics, Third Party Medicine and Governmental Relations.
Commission on Continuing Education and Health Manpower.
Commission on Medical-Legal Affairs.
Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The Chair of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chair of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to the President by the specialty organization. In the event that such a nominee is not submitted by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Medical Student Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the four independent Medical School Component Societies in the state.

Section 2. Governing Council. There shall be a Governing Council of the Medical Student Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be five voting members of the Governing Council, consisting of the officers, the Student Councilor and the Student Vice-Councilor.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice-Councilor. The Councilor and Vice-Councilor shall be elected by the members of the respective Medical School Component Society. The following sequence shall be used in determining the Medical School Component Society from which the Councilor and Vice-Councilor shall be elected on an annual rotating basis: Washington University, St. Louis University, the University of Missouri-Kansas City, the University of Missouri-Columbia.

(f). Delegates. Each Medical School Component Society shall elect two Delegates to represent the Medical Student Section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Councilor and Vice-Councilor shall serve one-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Section Meeting. There shall be a meeting of members of the section held prior to each Annual Meeting of the MSMA House of Delegates.

Section 7. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the Medical Student Section.

Section 8. Purpose of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect a Chair, Vice Chair, and Secretary-Treasurer.

(e). To conduct such other business as may properly come before the meeting.

Chapter IX. Organized Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Organized Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegates and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Organized Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Organized Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary-Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter X. Resident Physicians Section

Section 1. Membership. The Resident Physicians Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physicians Section. The Governing Council shall consist of the officers of the Resident Physicians Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physicians Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resident Physicians Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physicians Section.

Section 2. Officers. The Members attending the Business Meeting of the Resident Physicians Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chair. The Chair shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physicians Section.

(b). Vice Chair. The Vice Chair shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physicians Section, in the absence of the Chair or at the request of the Chair.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physicians Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physicians Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chair, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physicians Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter XI. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be $300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for resident members shall be $20 per year; student members shall be assessed dues of $5 per year; honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section, for the calendar year in which they join.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his/her name is properly reported and his/her dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XII. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his/her specialty or logical extension of his/her field of expertise or who interferes with the proper administration of justice by misrepresenting his/her qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his/her testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XIII. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Davis' Rules of Order*.

Chapter XIV. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding the disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold membership in that component society most convenient for the physician to attend, on permission of the component society in whose jurisdiction the physician resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him/her shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, the member shall be given a written certificate of these facts by the secretary of the society, without cost, for transmission to the secretary of the society in the jurisdiction to which he/she moves. Pending the acceptance or rejection by the component society to which the physician moves, such member shall be considered to be in good standing in the component society from which he/she was certified and in the State Association to the end of the period for which dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit membership in this Association and the Secretary shall remove the member's name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he/she becomes a member of the component society of the area to which he/she has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Organized Medical Staff Section, the Medical Student Section and the Resident Physicians Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, or 5 of these Bylaws. The Secretary of each component society, the Organized Medical Staff Section, the Medical Student Section and the Resident Physicians Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He/She shall send a copy of the program of each meeting to the district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XV. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chair and Vice Chair and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the Missouri State Medical Association Council.

Chapter XVI. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XVII. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

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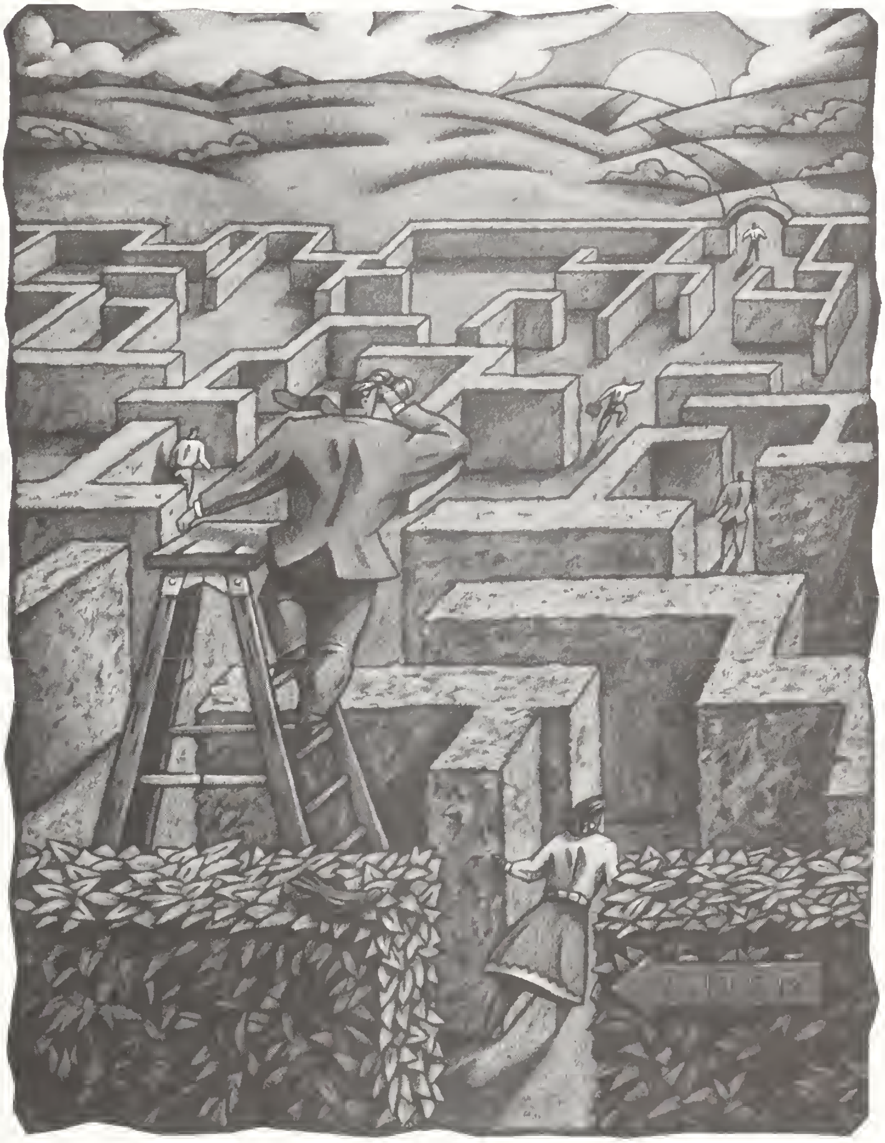

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Committees and Commissions

Executive Committee

*Daniel O'Sullivan, MD, *St. Louis*
A. J. Campbell, MD, *Sedalia*
Norman Knowlton, III, MD, *Springfield*
Edmond Cabbabe, MD, *St. Louis*
Frederick Hahn, MD, *Independence*
David Wilkinson, MD, *St. Louis*
Stephen Vilmer, MD, *Parkville*
William Dorzab, MD, *Raytown*

Council on Ethical and Judicial Affairs

	Term expires
Eugene Hansbrough, MD, *Poplar Bluff*	*2000*
*Hugh Stephenson, Jr., MD, *Columbia*	*1999*
Thomas Cooper, MD, *Farmington*	*1998*
Ronald Youmans, *Kansas City*	*1997*

Legislative Affairs Committee

David Barbe, MD, *Mountain Grove*
A. J. Campbell, MD, *Sedalia*
William Dorzab, MD, *Raytown*
Frederick Hahn, MD, *Independence*
Mrs. Joan H'Doubler, *Springfield*
Deborah Jantsch, MD, *Kansas City*
Jerry Kennett, MD, *Columbia*
Norman Knowlton, III, MD, *Springfield*
*Robert Miller, MD, *St. Louis*
Mrs. Becky Moore, *Joplin*
Charles Norland, MD, *St. Louis*
Daniel O'Sullivan, MD, *St. Louis*
Charles Porter, MD, *Kansas City*
Robert Schaaf, MD, *St. Joseph*
William Shell, MD, *Sikeston*
Robert Wankum, MD, *Jefferson City*
David Wilkinson, MD, *St. Louis*
Carol Williams, MD, *St. Louis*

Committee on Constitution & Bylaws

	Terms expire
Sheila Shah, MD, *St. Joseph*	*1999*
Jean Chapman, MD, *Cape Girardeau*	*1999*
*Donald Potts, MD, *Kansas City*	*1998*
Arteso Raborar, MD, *Springfield*	*1997*
Lawrence Lampton, MD, *Columbia*	*1997*

Continuing Education & Health Manpower

	Terms expires
J. David Auner, MD, *Ironton*	*1999*
David Fleming, MD, *Moberly*	*1999*
J. Thomas Critchlow, MD, *Cape Girardeau*	*1999*
David Martin, MD, *Chesterfield*	*1999*
George Trimble, MD, *Kansas City*	*1999*
Mark McClung, MD, *Kansas City*	*1998*
William Larsen, MD, *Shawnee Mission, KS*	*1998*
Aly Mohsen, MD, *Springfield*	*1998*
*Michael Vannier, MD, *St. Louis*	*1998*
Gerald Duling, MD, *St. Charles*	*1997*
David Glover, MD, *Warrensburg*	*1997*
William Gondring, MD, *St. Joseph*	*1997*
Richard Heimburger, MD, *Osage Beach*	*1997*
John Kelly, MD, *Joplin*	*1997*

Interspecialty Medicine Commission

Mark Vandewalker, MD, *Jefferson City -*
Missouri State Allergy Association
Don Cole, MD, *Springfield -*
Missouri Society of Anesthesiologists
George Hruza, MD, *St. Louis -*
Missouri Dermatological Society
Michael Szewczyk, MD, *Columbia -*
American College of Emergency Physicians, Mo. Chapt.
Mark Martin, MD, *Lee's Summit -*
Missouri Academy of Family Physicians
James Rogers, MD, *Springfield -*
Missouri Society of Internal Medicine
Joseph Hanaway, MD, *St. Louis -*
Missouri State Neurological Association
David Jimenez, MD, *Columbia -*
Missouri State Neurosurgical Society
John Anstey, MD, *St. Ann -*
American College of OB-GYN, Mo. Sect.
Matthew Lewis, MD, *Jefferson City -*
Missouri Ophthalmological Society, Inc.
Thomas Highland, MD, *Columbia -*
Missouri State Orthopaedic Association
Greg Renner, MD, *Columbia -*
Missouri Society of Otolaryngology
Michael Caughron, MD, *Kansas City -*
Missouri Society of Pathologists
Ted Groshong, MD, *Columbia -*
American Academy of Pediatrics, Mo. Chapt.
Thomas Lieb, MD, *Clayton -*
Central Soc. of Physical Medicine & Rehabilitation
William Huffaker, MD, *Chesterfield -*
Mo. Assn. of Plastic & Reconstructive Surgery

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* - Committee Chair

Tom Anderson, MD, *Columbia* - *Missouri Psychiatric Association*
Michael Bukstein, MD, *Hannibal* - *American College of Surgeons, Mo. Chapt.*
Roger A. Francis, MD, *Linn Creek* - *Missouri Radiological Society*
Dennis Pyszczynski, MD, *Kansas City* *Missouri Thoracic Society*
Michael Chehval, MD, *St. Louis* - *Missouri Urological Society*

Medical Economics, Third Party Medicine & Governmental Relations Commission

	Terms expires
Emil Miskovsky, MD, *St. Louis*	*1999*
Don Cole, MD, *Springfield*	*1999*
Steve Buie, MD, *Kansas City*	*1999*
Phillip Hornbostel, MD, *Sedalia*	*1999*
Richard Gutknecht, MD, *Independence*	*1999*
Mila Cunningham, MD, *Columbia*	*1998*
Ronald Riner, MD, *St. Louis*	*1998*
Michael Bukstein, MD, *Hannibal*	*1998*
William Stricker, MD, *Jefferson City*	*1998*
*Randall Treadwell, MD, *Chesterfield*	*1998*
George Hubbell, MD, *Osage Beach*	*1997*
Ann Peick, MD, *Poplar Bluff*	*1997*
James Rogers, MD, *Springfield*	*1997*
Narendra Shah, MD, *St. Joseph*	*1997*
Carl Strauss, MD, *Kansas City*	*1997*

Commission on Medical-Legal Affairs

	Terms expires
Grant Bever, MD, *St. Louis*	*1999*
Howard Braby, MD, *Independence*	*1999*
Gregory H. Branham, MD, *St. Louis*	*1999*
Ronald Morley, DO, *Jefferson City*	*1999*
James Criscione, Jr., MD, *St. Louis*	*1999*
Edmond Cabbabe, MD, *St. Louis*	*1998*
Darrel Domann, MD, *Springfield*	*1998*
Roger Francis, MD, *Linn Creek*	*1998*
Ted Groshong, MD, *Columbia*	*1998*
*Marc Taormina, MD, *Independence*	*1998*
Kenneth Bennett, MD, *St. Louis*	*1997*
Joseph Corrado, MD, *Mexico*	*1997*
William Snidle, MD, *Crystal City*	*1997*
Gus Wetzel, MD, *Clinton*	*1997*

Physicians' Health Committee

	Terms expires
John Lyskowski, MD, *Jefferson City*	*1999*
Thomas Cochran, MD, *Springfield*	*1999*
Charles Sincox, MD, *Washington*	*1999*
Michael Freeman, MD, *Cape Girardeau*	*1999*
*Thomas Anderson, MD, *Columbia*	*1998*
Donald McIntosh, MD, *Lee's Summit*	*1998*
K. Lynn Moritz, MD, *St. Louis*	*1998*
Hugh Bartlett, MD, *Rolla*	*1997*
Jo-Ellyn Ryall, MD, *St. Louis*	*1997*

Planning Committee

	Terms expires
Laureano Mayuga, MD, *Cabool*	*2001*
Robert Zahn, MD, *Springfield*	*2001*
Stephen A. McCray, MD, *Kansas City*	*2000*
*Herluf G. Lund, Jr., MD, *Chesterfield*	*2000*
Roy Michael, DO, *Jefferson City*	*1999*
Nancy Weber-Bornstein, MD, *Cape Girardeau*	*1999*
Michael J. Curry, MD, *St. Charles*	*1998*
James L. Stewart, MD, *Weatherby Lake*	*1998*
Phillip M. Hornbostel, MD, *Sedalia*	*1997*
Ronald L. Phillips, MD, *Kirksville*	*1997*

Public Affairs Commission

	Terms expires
Jennifer Ashby, MD, *N. Kansas City*	*1999*
Nancy Bunge, MD, *Mexico*	*1999*
Ronnie Brownsworth, MD, *Springfield*	*1999*
Suzanne Miller, MD, *Grover*	*1999*
Michael Szewczyk, MD, *Columbia*	*1999*
Diane Brukardt, MD, *Columbia*	*1998*
Steve Halpin, MD, *Hannibal*	*1998*
Ravi Mehra, MD, *St. Louis*	*1998*
W. Mike See, MD, *Columbia*	*1998*
*Ann Peick, MD, *Poplar Bluff*	*1998*
James Blaine, MD, *Springfield*	*1997*
Shavonne Danner, MD, *Leawood, KS*	*1997*
Warren Lovinger, Jr., MD, *Nevada*	*1997*
K. Lynn Moritz, MD, *St. Louis*	*1997*
Kelvin Walls, MD, *Independence*	*1997*

Publications Committee

Philip C. Anderson, MD, *Columbia*
John S. Daniels, MD, *St. Louis*
John C. Hagan, III, MD, *N. Kansas City*
Donald G. Sessions, MD, *Kirkwood*
*J. Regan Thomas, MD, *St. Louis*

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* - Committee Chair

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Contact: Mary Benoist, Dept. of Internal Medicine
1402 S. Grand Blvd., St. Louis, MO 63104
Tel (314)577-8762; Fax (314)268-5108

Missouri State Allergy Association
President: Mark Vandewalker, MD
Contact: Linda Bremer, Executive Director
113 Madison, P.O. Box 1028
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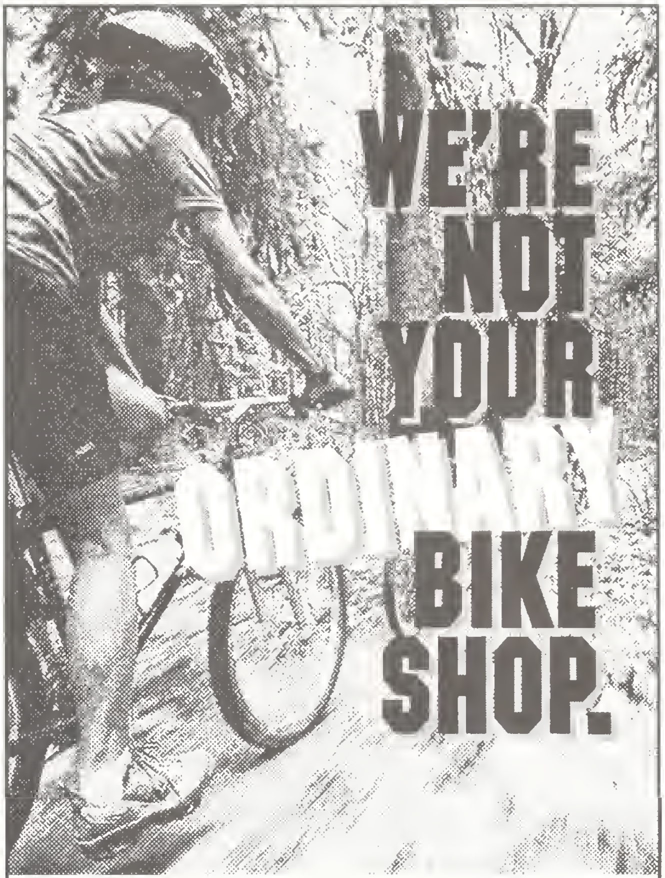

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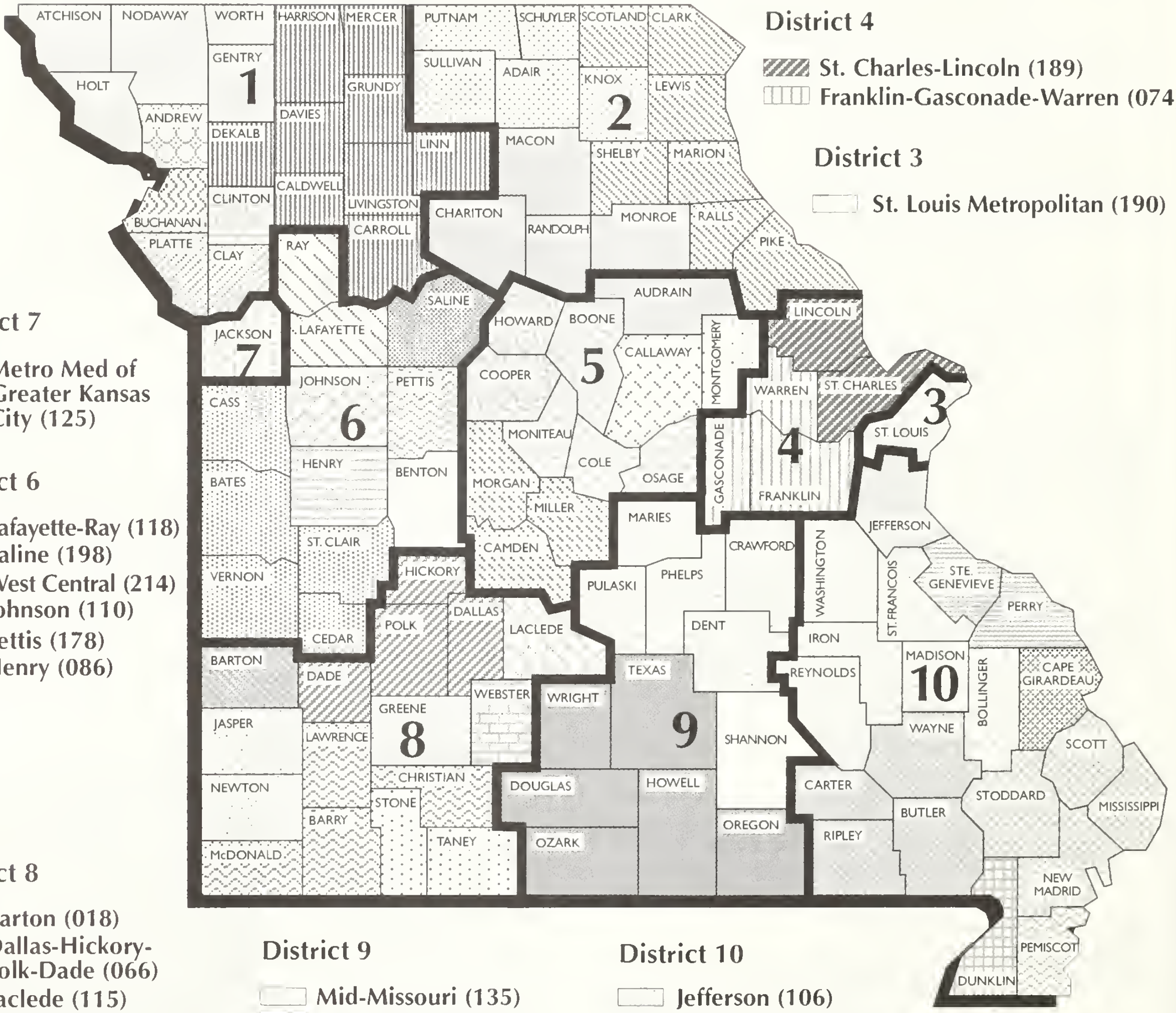
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***Abbadessa, Steven M**	St. Louis	190
Abbey, Elliot E	St. Louis	002
Abdou, Nancy L	Shawnee Mission, KS	125
Abel, Charles C	St. Louis	190
Abele, William A	Boonville	026
Abella, Ben Zulueta	Belton	125
Abend, Melvin N	Kansas City	125
Abercrombie, Keith J	Kansas City	125
Abernathie, Dennis L	Columbia	026
Abinoja, Conrado B	St. Louis	190
Abodeely, Daniel A	St. Louis	190
Abrams, Bernard M	Kansas City	125
Abu Dalu, Ziad	St. Louis	190
Aceto, Thomas, Jr.	St. Louis	190
Acuff, R. Phillip	St. Joseph	030
Adams, Allen G	St. Louis	190
Adams, Dawn	Independence	215
Adams, John G	Cape Girardeau	042
Adams, Kenneth A	Independence	125
Adams, Mark A	Columbia	026
Adams, Riley R	Cape Girardeau	042
Adams, Stephen R	Springfield	082
Adams, Susan E	St. Louis	190
Adelman, Arthur	Shawnee Mission, KS	125
Adelmann, Eugene	St. Louis	190
Adkins, Charlene	Columbia	026
***Adkison, Brian W**	Seymour	082
Adler, Benard C	St. Louis	190
Adler, Federico	Kansas City	125
Aeder, Mark 1	Kansas City	125
Aff-Drum, Helen	St. Louis	190
Afuwape, Emanuel A	E. St. Louis, IL	190
Aguinaldo, Jaime A	St. Louis	190
Ahadi, Abd U	St. Louis	190
Ahern, Archibald M	St. Louis	190
Ahlering, Christopher L	St. Louis	190
Ahlering, George H	St. Louis	190
Ahlering, George P	St. Louis	190
Ahlum, Sandra J	Hannibal	150
Ahlvin, Robert C	Sikeston	202
Ahmad, Bashir	Pacific	190
Ahmad, Musaddeque	Potosi	138
Ahmad, Naseer	St. Louis	190
Ahmad, Nusrat J	Chesterfield	190
Ahmad, Salama S	Chesterfield	190
Ahmann, Thomas M	Mexico	014
Ahnemann, Janet L	Clinton	086
Ahuja, Suraj P	Kansas City	125
Ailor, Edgar 1	Columbia	026
Ailor, Susan K	Columbia	026
Ajans, Zaki A	Mexico	014
Akers, Joan E	Kansas City	125
Akin, C. David	Independence	125
Akremi, Janet E	Warrensburg	110
Al-Aly, Robert M	Chesterfield	190
Alander, Dirk H	Kansas City	125
Alba, Laura M	Kansas City	215
Albani, Frank J	Liberty	050
Albanna, Faisal J	St. Louis	190
Albano, Benj I	Crystal City	106
Albano, Grace A	Independence	125
Albera, Victor H	St. Clair	190
Alberg, Marvin R	Kansas City	125
Albert, 1. Renee	St. Louis	190
***Albracht, Bryan J**	Chatham, IL	215
Albritton, Michael A	Springfield	082
Alcancia, Elpidio Y	Springfield	082
Alderman, Lillian C	Liberty	050
Aldridge, George A	Poplar Bluff	034
Alegre, Jorge M	Chesterfield	190
Aleksander, Bernardo G	El Paso, TX	190
Alex, Morris	St. Louis	190
Alfie, Salomon	Shawnee Mission, KS	125
Allain, James J	Shawnee Mission, KS	050
Allan, James E	Jefferson City	058
Allan, James R	Columbia	026
Allcorn, Donald K	Lincoln	178
Allego, Melquiadito M	Perryville	174
Allen, Arthur A, 11	Shawnee Mission, KS	125
Allen, Brent T	St. Louis	190
Allen, David O	Bella Vista, AR	102
Allen, James H	St. Louis	190
Allen, Jerry H	Springfield	082
Allen, Jerry H	Washington	074
Allen, Mark J	Kansas City	125
Allen, Melvin A	St. Louis	190
Allen, Robert E	Shawnee Mission, KS	125
Allen, Thomas P	Overland Park, KS	125
Allen, William C	Columbia	026
Allen, William Corwin	Columbia	026
Allison, James B	Springfield	082
Allphin, Allan L	Springfield	082
Allyn, Steven L	Springfield	082
Almiron, Osias A	House Springs	190
Almuttar, Wasif F	Maryville	158
Alonso-Yague, Pascual	Florissant	190
Al-Shathir, Saad	Joplin	102
Alsop, Webb S, Jr.	Shawnee Mission, KS	125
Altepeter, H. Martin	St. Louis	190
Alvarez, Ulises C	Florissant	190
Alyea, James O	Columbia	026
Ames, Mary B	Santa Cruz, CA	125
Amin, Navin J	St. Louis	190
Amini, Jafar	Shawnee Mission, KS	125
Amjad, Mohammad T	St. Louis	190
Ammala, Edward D	Rolla	135
Ancheta, Apolinario A	Springfield	082
Anderson, D. Claire	St. Louis	190
Anderson, Daphne W	Springfield	082
Anderson, David J	St. Louis	190
Anderson, David R	Cape Girardeau	042
Anderson, Frank K	St. Charles	189
Anderson, Paul B	Neosho	166
Anderson, Philip C	Columbia	026
Anderson, Raymond B	Shawnee Mission, KS	125
Anderson, Thomas R	Columbia	026
Andres, Edward H	St. Joseph	030
Andrew, Christopher R	Joplin	102
Andrews, Elizabeth J	Springfield	082
***Andrews, Lynthia B**	Lexington	030
Andrews, Paul E	Springfield	082
Andrus, Bailey C	Leawood, KS	125
Andrus, Charles H	Westchester, IL	190
Anglen, Jeffrey O	Columbia	026
Anglo, Luis J	St. Louis	215
Anglo, Luis B	St. Louis	190
Anslinger, David L	Chesterfield	190
Anstey, George C	St. Ann	190
Anstey, John T	St. Ann	190
Anthony, Dallas D	Springfield	082
Anthony, James P	Kansas City	125
Apostol, Andres G	Monett	166
Appelbaum, John K	St. Louis	002

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Applegate, Clara	West Plains	**206**
Applewhite, Thomas A	St. Louis	**190**
Apprill, Phillip G	St. Louis	**190**
Apte, Sunil M	Washington	**074**
Arbab, Ali A	Kansas City	**125**
Arenos, Proceso T	St. Louis	**190**
Arkin, Steven M	Kansas City	**125**
Armbruster, A. A	Stilwell, KS	**002**
Armstrong, Jay H	N. Kansas City	**050**
Armstrong, Stephen D	Springfield	**082**
Arneson, Axel N	St. Louis	**190**
Arney, William G	St. Louis	**190**
Arnold, Donald E	St. Louis	**190**
Arnold, John D	Scottsdale, AZ	**125**
Arnold, Kenneth J	Chesterfield	**190**
Arnold, Paul N	Springfield	**082**
Aronberg, Jerome M	St. Louis	**190**
Arora, Ravinder S	Sedalia	**178**
Arribas, Neva P	St. Louis	**190**
Arst, Herbert E	Kansas City	**050**
Arthaud, J B	Columbia	**026**
Arthur, Gerald L	Columbia	**026**
Asel, Norman D	Columbia	**026**
Ash, Charles J	Springfield	**082**
Ashby, Jennifer D	N. Kansas City	**125**
Ashcraft, Keith W	Overland Park, KS	**125**
Asher, Irving M	Columbia	**026**
***Asher, Kennett D**	Jackson	**042**
Ashley, Lillard G, Jr.	Kansas City	**125**
Ashley, Michael E	Springfield	**082**
Ashley, Thomas E	Springfield	**082**
Askew, John H	Sikeston	**202**
Assi, Nizar A	Chesterfield	**190**
Atwell, Floyd C	Shawnee Mission, KS	**125**
Atwood, Steven D	Springfield	**082**
Aubuchon, Craig E	St. Louis	**190**
Auclair, Ronald J	St. Louis	**190**
Auer, Arthur I	St. Louis	**190**
Aufderheide, G. Russell	St. Louis	**190**
Aulenbacher, Carl E	Ft. Lauderdale, FL	**074**
Auner, J. David	Ironton	**138**
Avallone, Anthony N	Springfield	**082**
Avins, Laurence R	St. Louis	**190**
Avioli, Louis V	St. Louis	**190**
***Awad, Ahmed M**	Kansas City	**215**
Awadalla, Sylvia	St. Louis	**190**
Axness, Mark E	Springfield	**082**
Ayata, Sedat M	Chesterfield	**190**
Aydt, Sarah A	Cape Girardeau	**042**
Aylward, Howard J, Sr.	Santa Barbara, CA	**190**
Ayvazian, Vatche H	St. Louis	**190**
Azan, Kenneth N	Sedalia	**178**

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***Baade, Norman F**	St. Joseph	**030**
Babka, Joseph J	St. Louis	**190**
Bach, Lysle M	Hannibal	**150**
Back, Donald K	Springfield	**082**
Backer, Matt H, Jr.	San Diego, CA	**190**
Backer, Robert J	St. Louis	**190**
Backstrom, Jay T	Kansas City	**125**
***Bader, Larry W**	Columbia	**026**
Badwey, Timothy M	Kansas City	**125**
Bagby, Jack M, Jr	Springfield	**082**
Baglan, Robert J	St. Louis	**190**
Bagwe, Lata R	St. Louis	**190**
Bahn, Charles F	Prescott, AZ	**042**
Bai, Samuel S	Festus	**106**
Bailey, Alan H	Springfield	**082**
Bailey, Colin E	Columbia	**026**
Bailey, Gregory J	St. Louis	**190**
Bailey, Hugh R	Kansas City	**002**
Bailey, Sean B	St. Louis	**215**
Bailiff, Robert	Springfield	**082**
Baird, Keim L	St. Charles	**189**
Baker, Carl N	St. Louis	**190**
Baker, Donald L	Union	**074**
Baker, John H	St. Louis	**190**
Baker, Josephine D	Moberly	**046**
Baker, Marion H	Jefferson City	**058**
Baker, Philip J	Independence	**125**
Baker, Sherwood	Columbia	**026**
Baker, Tim E	Washington	**074**
Balakrishnan, Roja	Rolla	**135**
Balcer, Charlotte M	Jefferson City	**058**
***Balcer, Conrad S**	Jefferson City	**058**
Baldwin, Richard, Jr.	St. Louis	**190**
Baldwin, Theodore R	Excelsior Springs	**118**
Bale, Robert D	St. Louis	**190**
Balfe, Dennis M	St. Louis	**190**
Ball, David A	Joplin	**102**
Ballard, V. Bryce	Shawnee Mission, KS	**125**
Ballinger, Walter F	St. Louis	**190**
Balster, Vernon H	St. Louis	**190**
Bandle, Donald F	St. Louis	**190**
Banerjee, Dilip	Washington	**074**
Banton, M. Roman	St. Louis	**190**
Banton, Thomas J, Jr.	St. Louis	**190**
Banton, William C, II	St. Louis	**190**
Barbe, David O	Mountain Grove	**206**
Barbee, Charles W	Columbia	**026**
Barber, Gregory B	Kansas City	**125**
Barbieri, Craig D	Kansas City	**215**
Barbour, Marvin R	Poplar Bluff	**034**
Bardsley, John L	St. Louis	**190**
Bare, Chester I, Jr.	Raytown	**125**
Bare, Edward F	Tarkio	**158**
Bareis, Robert J	Marshfield	**210**
Barelli, Pat A	Leawood, KS	**125**
Bari, Wagih A	St. Louis	**190**
Barjenbruch, Peggy W	Mexico	**014**
Barker, Edward T	St. Louis	**190**
Barloon, James H	Shawnee Mission, KS	**125**
Barlow, Val John	Chesterfield	**190**
Barnard, John L, Jr.	Kansas City	**125**
Barnes, Charles H	Kansas City	**125**
Barnes, Larry G	Neosho	**166**
Barnett, Floyd A	Paris	**046**
Barnhill, Floyd R	Springfield	**082**
Barnthouse, Cris D	Kansas City	**125**
Barnthouse, Joseph R	Kansas City	**125**
***Barnum, Grant M**	Osage Beach	**120**
Barr, Glenn A	Kansas City	**125**
Barr, W. Kent	N. Kansas City	**125**
Barragan, Hector D	St. Louis	**190**
Barrett, Scott R, Sr.	Columbia, MD	**190**
Barrido, Lemuel T	Potosi	**138**
***Barrow, Chelmer L, Jr.**	Lake St. Louis	**190**
Barrow, Jack	St. Louis	**190**
Barry, William B	Kansas City	**125**
Bart, Gerald N	St. Louis	**190**
Bartell, Michael F	St. Louis	**190**
Barter, Bruce	Leawood, KS	**125**
Bartlett, Hugh C	Rolla	**135**
Bartlett, John E	Springfield	**082**
Bartley, Richard L	Springfield	**082**
Barton, Premsri T	St. Louis	**190**
***Bartow, John H**	St. Joseph	**030**
Bartulica, Nicholas	St. Joseph	**030**
Bashyakarla, Rajeeva K	Joplin	**102**
Baskurt, Mehmet V	Poplar Bluff	**034**
Bass, Barry J	Rolla	**135**
Bass, Walter R	Raytown	**125**
Bassiri, Haleh G	Kansas City	**215**
Bassman, Donald R	St. Louis	**190**
Batan-Co, Ruby L	Chesterfield	**190**
Batchu, Sudhir S	Columbia	**026**

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Bateman, Timothy M	125	Kansas City
Bates, G. Comer	050	Kansas City
Batterson, James R, Jr.	125	Kansas City
Batts, Barbara A	125	Kansas City
Batty, Thomas V	214	Eldorado Springs
Baudendistel, Lawrence J	190	St. Louis
Bauer, Daniel J	190	St. Louis
Bauer, John D	190	St. Louis
Bauer, Lafe W	125	Overland Park, KS
Baula, Armindo G	190	St. Louis
Bauman, Alan E	125	Kansas City
Baumann, Albert R	135	Steelville
Baumgartner, Norbert E	042	Cape Girardeau
Bauschard, Frederick D	190	St. Louis
Bautista, Joel O	046	Moberly
Bautista, Rogelio L	046	Moberly
Bautz, James B	125	Kansas City
Bauwens, Daniel B	190	Chesterfield
Bayer, William L	125	Kansas City
Beal, Catherine E	190	St. Louis
Beall, McPherson S, Jr.	125	Kansas City
Beare, Lucia V	190	St. Louis
Beasey, Matthew D	215	Shawnee Mission, KS
Beato, David L	190	St. Louis
Beaty, William R	190	St. Ann
Beauchamp, Gary D	125	Shawnee Mission, KS
Beck, Marcus R	026	Columbia
Beck, Paul M	030	St. Joseph
Becker, Bernard	190	St. Louis
Becker, Robert L	190	St. Louis
Becker, Rolfe A	125	Kansas City
Becker, Stanley C	190	St. Louis
Becker, William L	190	St. Louis
Beckett, Wm. Wilson	026	Columbia
Beckette, Edmund	190	St. Louis
Beckman, Robert F	002	St. Louis
Beckmann, Charles R.B.	125	Kansas City
Bedwinek, John M	190	St. Charles
Beeks, John W	125	Kansas City
Beesley, Kari	002	Kansas City
Beggs, Charles W	050	Liberty
Beguin, Everett A, Jr.	082	Springfield
Behbahani, Parviz M	190	Bridgeton
Beheler, Edward M	030	St. Joseph
Behrends, Steven H	125	Kansas City
Behrens, Donald T	190	St. Louis
Behrens, Gerald L	190	St. Louis
Beitman, Bernard D	026	Columbia
Belden, Jeffery L	026	Columbia
Belen, Marietta	106	Festus
Belew, Joe E	190	Chesterfield
Belew, Mark	190	Florissant
Bell, Laird A	082	Springfield
Bell, Malinda H	125	Shawnee Mission, KS
Bell, Martin J	190	St. Louis
Bell, Stephen	190	St. Louis
Bell, William F	125	Lee's Summit
Bellamy, Bruce G	086	Clinton
Beller, Thomas A	125	Kansas City
Belshe, Sidney B	058	Jefferson City
***Belson, Ian L**	125	Kansas City
Belz, Norbert T	082	Springfield
Benage, Clarence M	190	St. Louis
Benecke, James E, Jr.	190	St. Louis
Benedett, Robert E	082	Springfield
Benedict, Holly J	082	Ozark
Benedict, William W	190	Chesterfield
Benitez, Jose A	190	St. Louis
Bennett, Danny L	125	Kansas City
Bennett, Donald R	215	Columbia
Bennett, James D	125	Leawood, KS
Bennett, John E	058	Jefferson City
Bennett, Kenneth J	190	St. Louis
Benoist, Walter F	190	Chesterfield
Benson, Larry E	050	N. Kansas City
Benson, Ronald G	082	Springfield
Benson, Russell L	125	Kansas City
Benson, William F	125	Kansas City
Bentlage, Charles H	102	Joplin
Bentley, John D	082	Springfield
Benton, Mary Beth	026	Columbia
Berdy, Gregg J	190	St. Louis
Berdy, Susan S	190	St. Louis
Berg, Edward F	190	Chesterfield
Berg, Leonard	190	St. Louis
Berg, Ralph	190	St. Louis
Bergmann, Daniel J	189	St. Peters
Berkowitz, Ellis R	030	St. Joseph
Berkowitz, Wallace P	190	St. Louis
Berland, Harry I	190	St. Louis
Berman, Paul M	190	St. Louis
Berman, William	190	St. Louis
Bernabe, Florinio H	190	St. Louis
Bernabe, Ofelia M	190	St. Louis
Bernard, Jennifer P	215	Overland Park, KS
Bernard, Lisa	125	Kansas City
Bernardi, Robert J	190	St. Louis
Berndsen, Gerard H	190	St. Louis
Berner, Carol T	082	Springfield
Bernhardt, Gary D	125	Overland Park, KS
Bernhardt, Mark	125	Kansas City
Berni, Anthony A	190	St. Louis
Bernstein, Aaron M	190	St. Louis
Berry, Danny T	042	Cape Girardeau
Berry, Maxwell G	125	Shawnee Mission, KS
Berry, Paul T	082	Springfield
Berson, Douglas R	002	Chesterfield
Berwald, David M	190	Bridgeton
Berwald, Irvin I	190	Bridgeton
Bessonny, Eric J	190	St. Louis
Best, John A	190	Chesterfield
Bettinger, Irene E	125	Kansas City
Bettonville, Peter V	190	St. Louis
Betz, Richard J	166	Neosho
Betz, Robert F	166	Neosho
***Betz, William T**	125	Grandview
Bhattacharya, Arjun	190	St. Louis
Bhothinard, Bhisit	034	Poplar Bluff
Biber, Robert J	125	Independence
Bickley, James E	125	Evergreen, CO
Biel, Stanley I	190	Bridgeton
Bieniek, Christopher M	150	Hannibal
Biery, Richard M	125	Kansas City
***Bieser, R. Dan**	042	Cape Girardeau
Bigg, Steven W	190	St. Louis
Biggs, Alfred D, Jr.	125	Kansas City
Biggs, Fred J	034	Poplar Bluff
Biggs, Harry L	125	Galena
Biggs, John	190	St. Louis
Billadello, Joseph J	002	St. Louis
***Billings, Christopher W**	082	Springfield
Billy, Lawrence J	190	St. Louis
Binda, Robert E	125	Kansas City
Bindbeutel, Donald A	190	Sun City West, AZ
Binnington, H B	190	St. Louis
Binz, Donald E	189	St. Peters
Birchansky, Bonnie-Lee	030	St. Joseph
Bircher, John L	190	St. Louis
Bird, H. Waldo, Jr.	190	St. Louis
Birenboim, Nancy	125	Kansas City
Birge, Clifford A	190	St. Louis
Birkby, William F	026	Columbia
Birmingham, Jean E	190	St. Louis
Birnbaum, Elisa H	190	St. Louis
Bishop, Marion D	190	St. Louis
Bitar, Saad R	215	Manchester
Bittle, Bradley K	042	Cape Girardeau
Bizek, J L	166	Aurora

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Black, David L	102	Joplin
Black, Don A	125	Prairie Village, KS
Black, Donald R	082	Springfield
Black, William R	102	Joplin
Blackburn, Michael D	026	Columbia
Blackwell, Charles W	026	Columbia
Blackwell, Charles R	190	St. Louis
Blades, Ross D	082	Springfield
Blaine, James R	082	Springfield
Blair, Jerry R	026	Columbia
Blair, Olga M	190	St. Louis
Blair, Vilray P, III	190	St. Louis
Blalock, Robert W	198	Marshall
Blank, Michael K	106	De Soto
Blanke, Thomas J	190	St. Louis
Blankenship, Dale M	042	Savannah, GA
Blaskiewicz, Robert J	190	St. Louis
Blath, Richard A	190	St. Louis
Blatt, Geoffrey L	125	Kansas City
Blim, R. Don	125	Kansas City
Bliss, Greg A	125	Independence
Block, Arnold S	190	St. Louis
Block, Jared G	215	Columbia
Bloom, Stephen A	125	Overland Park, KS
Bloomberg, Gordon R	190	Chesterfield
Bluestone, Kenneth I	125	Leawood, KS
Blum, Carol A	002	Excelsior Springs
Blum, Donald A	190	St. Louis
Blum, Philip C	125	Kansas City
Blythe, James G	190	St. Louis
Boatright, Kevin	138	Farmington
Bode, Eugene T	125	Kansas City
Bodney, Maj., Stephen A	135	Ft. Leonard Wood
Bogart, Douglas B	125	N. Kansas City
Bogner, Stuart M	190	St. Louis
Bohigian, George M	190	St. Louis
***Bohn, Sara A**	058	California
Bohn, William W	125	Kansas City
***Boice, Brett E**	102	Joplin
Boice, Michelle A	102	Joplin
Boland, Michael F	190	Chesterfield
Boldizar, Albert G	190	St. Louis
Boldt, Thomas H	190	Bridgeton
Boles, C R	190	St. Louis
Boles, Murray	026	Columbia
Bolinske, Robert E	190	St. Louis
Bollozos, George D	190	Chesterfield
Bonacorsi, John	190	Bridgeton
Bonar, Susan K	125	Kansas City
Bondurant, Charles P	026	Columbia
Bonebrake, Albert J	082	Springfield
Bonebrake, Mac D	082	Springfield
Bonfanti, Albert L	190	Chesterfield
Bonham, Roger D	026	Columbia
Boniuk, Isaac	190	St. Louis
Bonner, James S	190	St. Louis
Bonney, Saml C	074	Washington
Bonsanti, Robert L	190	Bridgeton
Boone, Martin H, Jr	082	Springfield
Boonshaft, Benje	190	St. Louis
Bopp, J. Ronald	102	Seneca
Bordy, Marvin D	125	Kansas City
Borello, Dan J	102	Joplin
Borhani, Hesamodin	215	Kansas City
Borja, Egbert R	082	Springfield
Borkon, A. Michael	125	Kansas City
Borowsky, Benj A	190	St. Louis
Borrego, Raul A	138	Farmington
Borup, Jerrell L	082	Springfield
***Bosley, Carl E**	034	Poplar Bluff
Bost, Roger K	034	Poplar Bluff
Botney, Kathryn	190	Chesterfield
Botwin, Arnold E	125	Leawood, KS
Bouhasin, John D	190	St. Louis
Bourgeois, Curtis H	026	Columbia
Boutwell, Christine M	215	Kansas City
Boveri, Joseph C	190	St. Louis
Boveri, Lawrence V	002	St. Louis
Bowe, Christopher C	190	St. Louis
Bowen, Stephen F, Jr.	190	St. Louis
Bowenschulte, Bradley A	082	Springfield
Bowers, James E	190	Kirkwood
Bowersox, Warren A	190	Pacific
Bowles, G R	190	St. Louis
Bowles, Richard P	050	Liberty
Bowman, W. Kirk	042	Cape Girardeau
Bownik, Theodore B	050	Kansas City
Bowser, John F	125	Hot Springs, AR
Bowser, Robert L	050	Independence
Boyarsky, Saul	190	St. Louis
Boyce, John M	178	Blue Springs
Boyd, Craig W	190	St. Louis
Boyd, James H	190	St. Louis
Boydston, Catherine O	118	Odessa
Boydston, Wyatt W	118	Odessa
Boyer, Peter A	058	Jefferson City
Boylan, Peter C	125	Kansas City
Brabbee, Gregory W	190	St. Louis
Brabson, John H	082	Springfield
Braby, Howard H	125	Independence
Braddock, Stephen	026	Columbia
Bradford, John F	125	Shawnee Mission, KS
Bradley, J. Douglas	030	St. Joseph
Bradley, Richard V	190	St. Louis
Bradshaw, William D	125	Kansas City
Brady, Harry R	190	St. Louis
Brady, Hugh S	118	Concordia
Brady, Jane R	215	St. Louis
Brady, Teresa M	125	Raytown
Brancato, Donald H	190	St. Louis
Brangle, Robert W	190	St. Louis
Branham, Gregory H	190	St. Louis
Braun, Alan L	058	Jefferson City
Braun, William J	125	Kansas City
Braverman, Abe E	125	Overland Park, KS
Braverman, Stuart J	178	Sedalia
Braxton, Frank W	042	Cape Girardeau
Brazos, John C	178	Sedalia
Breckenridge, Robert L	050	Kansas City
Bredemann, Jeffrey A	125	Kansas City
Breeding, Lyle G	026	Columbia
Bregant, Robert E	058	Jefferson City
Brehm, G. Scott	102	Joplin
Brehm, Martha A	102	Joplin
Breite, Warren M	106	Festus
Brennan, George A	190	St. Louis
Brennan, James M	190	St. Louis
Brennan, Richard J	030	St. Joseph
Brennan, Robert A, Jr.	190	St. Louis
Brennan, Robert V	190	St. Louis
Brennan, Robert A, Sr.	190	St. Louis
Brent, Lanny R	082	Springfield
Bresnahan, Dennis R	125	Kansas City
Brewer, Joseph H	125	Kansas City
Brian, William J	082	Springfield
Bricker, Eugene M	190	St. Louis
Brigden, Robert B	102	Neosho
Briggs, Thomas B	082	Springfield
Brigham, David W	190	Ballwin
Bright, James E	082	Springfield
Brink, David S	215	St. Louis
Brinkman, Robert A	190	Chesterfield
Brischetto, Michael J	190	St. Louis
Britt, Cornelius L	106	Crystal City
Britton, Loretta M	125	Kansas City
Broaddus, Loren E	082	Springfield
Brock, Arthur L	125	Independence
Brockhaus, Jayne R	110	Warrensburg

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Brockman, M. Douglas Springfield	082
*Brocksmith, James T Columbia	026
Brodeur, Armand E St. Louis	190
Brodkey, Mark J Kansas City	125
Brody, Arnold G St. Louis	190
Bronson, Shael S St. Louis	190
*Bronson, Wendell D St. Joseph	030
Brook, Charles J Kansas City	125
Brookes, Robert D Chesterfield	190
Broun, Goronwy O, Jr. St. Louis	190
Brower, Clyde L Independence	125
Brown, Barry D St. Louis	190
*Brown, Carl D Kirksville	148
Brown, Cynthia L Poplar Bluff	034
Brown, David W Springfield	082
Brown, Elwyn S Kansas City	125
Brown, Frederick B Aurora	166
Brown, Freeman F, III Ballwin	190
Brown, James T Springfield	082
Brown, Katherine S Overland Park, KS	038
Brown, Merlin D St. Joseph	030
Brown, Michael S Hannibal	150
Brown, Mike J Cape Girardeau	042
Brown, Norbert W Kansas City	125
Brown, Rebecca L Springfield	082
Brown, Robert S Shawnee Mission, KS	125
Brown, Robert J St. Charles	189
Brown, Seymour Chesterfield	190
Browne, Jon E Kansas City	125
Brownsworth, Ronnie D Springfield	082
Bruce, Leo A Sikeston	202
Bruce, Robert P Kansas City	125
Brukardt, Diane T Columbia	026
Brumfield, Amy S Kansas City	215
Bruno, Patrick L Hannibal	150
Bruns, Kenneth St. Louis	190
Brunt, L. Michael St. Louis	190
Brunworth, David Washington	074
Bryant, Lester R Columbia	026
Bryant, T J Kansas City	125
Bryer, Mark P Columbia	026
Buchanan, Barbara N Kansas City	125
Bucher, William C Columbia	026
Buchert, Peter K Columbia	026
Bucholz, Richard D St. Louis	190
Buchwach, Kenneth A Independence	125
Buckner, John W Springfield	082
Buckner, Robert C Shawnee Mission, KS	125
Bucol, Kevin D St. Louis	190
Budd, John J, Jr. St. Louis	190
Budke, Harold A Kansas City	125
Buehler, Carl T, Jr Eldon	120
Buettner, John Brigham Chesterfield	190
Buffaloe, Robert N Jefferson City	058
Buie, Bruce R Kansas City	125
Buie, Steven E Kansas City	125
Bukstein, Michael J Hannibal	150
Bult, Mark J Springfield	082
Bumberry, Barbara A Springfield	082
Bumberry, John R Springfield	082
Bumgarner, James E Columbia	026
Bumgarner, Roger W Columbia	026
Bunge, Nancy J Mexico	014
Bunting, Williston P Kansas City	125
Burch, John E Naples, FL	102
Burch, Timothy K Overland Park, KS	125
Burcham, Tom R Farmington	042
Burdge, Robert E St. Louis	190
Burford, Edwin K Cape Girardeau	042
Burgdorf, Max H Bridgeton	190
Burgess, Dean St. Louis	190
Burk, Emmett K Plano, TX	050
Burke, James S, Jr. St. Louis	190
Burkey, Jordan W Springfield	082
Burkhart, Edward F Delray Beach, FL	190
Burks, Michael L Columbia	026
Burleigh, Bruce W Joplin	102
Burmeister, R. William St. Louis	190
Burns, Edward L St. Louis	190
Burns, Francis J St. Louis	190
Burns, Michael F St. Louis	190
Burns, Thomas W Columbia	026
Burris-Velloff, Tara M Prairie Village, KS	125
Burroughs, Nathan D N. Kansas City	050
Burst, Donald O St. Louis	190
Burstein, Robert St. Louis	190
Burton, Curtis D Hannibal	150
Busiek, Paul J Springfield	082
Busse, Paul P St. Louis	190
Bussmann, Carl E Bridgeton	190
Bussmann, Donald W Chesterfield	190
Bussmann, Donald W, Jr Springfield	082
Bussmann, Yvonne L Springfield	082
Butin, Richard E Kansas City	125
Butler, David F Chesterfield	190
Butler, Elza F St. Joseph	030
Butler, Susan M Jefferson City	058
Butsch, Richard H St. Peters	190
Butterfield, Mari Anne Lee's Summit	125
Butterworth, Nelson S Kansas City	125
Byars, Steven R Kansas City	125
Byland, Saml J Wellsville	146
*Bynum, Carl G Jefferson City	058
*Bynum, Robert L Ashland	026
Byrum, Fritz A Ballwin	190

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Cabbabe, Edmond B St. Louis	190
Cabral, Galileu Florissant	190
Cabrera, Tomas V St. Peters	189
Cacioppo, Joseph E St. Louis	190
Cady, Roger K Springfield	082
Caffrey, Raymond J Independence	125
Cain, Alvin R Lamar	018
Calabria, Rafael Nevada	214
Calaluce, Robert Columbia	215
Calbert, Cynthia C Kansas City	125
Caldwell, Fred Poplar Bluff	034
Caldwell, Fred M Poplar Bluff	034
Caldwell, Joseph L Springfield	082
Calhoun, Joshua W St. Louis	190
Callahan, Joseph D St. Louis	190
Callaway, Guy D, Jr Springfield	082
Callaway, Jo J Kansas City	125
Callaway, Lawrence A Kansas City	125
Callicoat, Paul E, Jr. Joplin	102
Calodney, Martin M St. Louis	190
Calovich, Emery R Shawnee Mission, KS	125
Camejo, Manuel Springfield	082
*Cameron, Roger W Jefferson City	058
Camp, Alan D Bridgeton	002
Campbell, Albert J Sedalia	178
Campbell, Daniel C Mount Vernon	166
Campbell, Edward D Cape Girardeau	042
Campbell, Gregory S Columbia	026
Campbell, J. William St. Louis	190
Campbell, James E Macon	046
Campbell, James W Advance	202
Campbell, William S, Jr Cape Girardeau	042
Campos, Francisco J St. Louis	190
Canaan, Samuel A, Jr. St. Louis	190
Canent, Ramon V Kansas City	125
Canlas, Mario P Springfield	082
Cannistraro, Rosemary L St. Louis	190
Cannon, Jenifer M St. Louis	002
Cannon, Max K Kirksville	148
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Canty, Eugene J	**189**	St. Charles
Caplin, David A	**190**	St. Louis
Carden, Juan O	**190**	St. Louis
Cardone, John C	**125**	N. Kansas City
Cardwell, Daniel R	**066**	Bolivar
Carey, Larry J	**082**	Springfield
Cargill, Dianna L	**050**	Liberty
Carleton, Charles E	**138**	Farmington
Carlin, M. Richard	**190**	St. Louis
Carls, Garry L	**190**	Imperial
Carlson, Arne E	**190**	St. Louis
Carlson, John V	**014**	Mexico
Carlton, Lynn N	**082**	Springfield
Carmody, John P	**190**	St. Louis
Carnahan, Charles E	**026**	Columbia
Carnes, Victor M	**102**	Durham, NC
Carney, Stephen E	**202**	Sikeston
Carney, Susan M	**050**	Kansas City
Carolla, Robert L	**082**	Springfield
Carpenter, George T	**030**	St. Joseph
Carpenter, James L	**189**	St. Charles
Carpenter, Wallace	**158**	Rock Port
Carr, George W	**058**	Jefferson City
Carr, Phillip W	**082**	Reeds Spring
Carranza, Mauro J	**190**	St. Louis
Carrier, John A	**190**	Ballwin
Carrington, Howard W	**115**	Lebanon
Carroll, Thomas W	**018**	Lamar
Carron, Oscar A	**174**	Perryville
Carter, Gary L	**050**	N. Kansas City
Carter, James R	**166**	Neosho
Carter, James E, Jr.	**125**	Leawood, KS
Carter, Robert L	**102**	Joplin
Caruso, Alfred A	**125**	Kansas City
Caruso, Alfred C	**215**	Kansas City
Cary, John M	**190**	Chesterfield
Case, Mary E	**190**	St. Louis
Case, William F	**125**	Kansas City
Casement, Brian A	**125**	Kansas City
Casey, Arthur L	**190**	St. Louis
Casey, Edwin J	**190**	St. Louis
Casey, Eliot C	**190**	St. Louis
Cashman, John W	**125**	Shawnee Mission, KS
Cason, Elbert H	**190**	St. Louis
Cassat, James D	**074**	Washington
Castaneda, Marco A	**190**	Bridgeton
Caster, Philip W	**115**	Lebanon
Catanzaro, Frank J, Sr.	**190**	St. Louis
Catanzaro, Frank J, Jr.	**190**	St. Louis
Catanzaro, Rudolph E	**190**	St. Louis
Cates, Joe A	**125**	Kansas City
Catron, David O	**042**	Cape Girardeau
Caughron, Michael R	**125**	Kansas City
Cavero, Fernando L	**066**	Bolivar
Centner, Paul J	**125**	Prairie Village, KS
Cento, Donald P	**202**	Sikeston
Cernik, Christine M	**190**	St. Louis
Chaffin, Jerald D	**208**	Branson
Chalk, David E	**074**	Washington
Chalkley, Judson I	**026**	Columbia
Chambon, Gregory E	**125**	Kansas City
Chamness, James T	**190**	St. Louis
Chan, Celia L	**042**	Cape Girardeau
Chanasue, John A	**190**	Florissant
Chandler, R. Allen	**125**	Sarasota, FL
Chandra, Mahesh	**125**	Independence
***Chandra, Ram**	**118**	Higginsville
Chandramohan, Nanjappa	**102**	Carthage
Chang, Chil K	**026**	Columbia
Chapman, James B	**042**	Cape Girardeau
Chapman, Jean A	**042**	Cape Girardeau
Charapata, Steven G	**125**	Kansas City
Charette, Richard P	**125**	Kansas City
Charles, Elaine Z	**190**	St. Louis
Charnas, Raymond M	**190**	St. Louis
Charnond, Siroth	**215**	Brentwood
Chase, Larry K	**082**	Springfield
Chase, Ned B	**102**	Joplin
Chastain, Charles W	**138**	Bonne Terre
Chatfield, Gina K	**215**	Columbia
Chaudhari, A. Basit	**042**	Cape Girardeau
Chaudhury, Triptesh K	**002**	Overland Park, KS
Chauhan, Nazar C	**034**	Poplar Bluff
Chavez, Salvador	**190**	St. Louis
Cheek, Charles W	**026**	Rocheport
Chehval, Micheal J	**190**	St. Louis
Chern, Mou S	**206**	Ava
Chernoff, Selbert G	**125**	Lee's Summit
Cherre, Charles J	**190**	Chesterfield
Chesney, George W	**102**	Joplin
Chesney, John W	**102**	Joplin
Cheuk, Shu-Sum	**190**	Chesterfield
Cheung, K. Charles	**042**	Cape Girardeau
Chien, David W	**190**	St. Louis
Chilton, Jonathan D	**125**	Kansas City
Chin, Mark Maw-Chang	**190**	Chesterfield
Chinsky, Murray	**190**	St. Louis
Chipongian, Raul A	**190**	St. Louis
Chirino, Octavio R	**190**	St. Louis
Chishti, M. Ishaq	**190**	St. Louis
Cho, Kyu S	**190**	St. Louis
Chod, Ronald J	**190**	St. Louis
Choi, Dennis W	**190**	St. Louis
Choi, Sei Young	**189**	St. Charles
Chou, Wesley H	**002**	Overland Park, KS
Choudhury, M. Hasan	**206**	Houston
Chouinard, Michael P	**202**	Sikeston
Christ, Martin H	**030**	St. Joseph
Christiansen, Sidney G	**030**	St. Joseph
Christiansen, Stephen D	**082**	Springfield
Christianson, Charles S	**166**	Mount Vernon
Christy, John P	**034**	Poplar Bluff
Christy, Raymond A	**082**	Springfield
Chu, Fred C	**190**	Chesterfield
Chu, Paul R	**125**	Independence
Chu, Peter Y	**125**	Kansas City
Chun, Chung S	**125**	Kansas City
Chun, Duck S	**190**	St. Louis
Chung, Kap Eun	**138**	Fredericktown
Chung, Sophia M	**190**	St. Louis
Chung, T. David	**034**	Poplar Bluff
Churchill, Robert J	**026**	Columbia
Ciapciak, Stanley J	**190**	St. Louis
Cibis, Gerhard W	**125**	Kansas City
Cipperly, Vaughan R	**102**	Joplin
Cirocco, William C	**125**	Shawnee Mission, KS
Clark, David P	**026**	Columbia
Clark, Granville E	**125**	Kansas City
Clark, Jennifer L	**026**	Columbia
Clark, Larry K	**102**	Joplin
Clark, Mark S	**215**	Lee's Summit
Clark, Robert C	**030**	St. Joseph
Clarke, Michael S	**082**	Springfield
Clarke, Michael J	**082**	Springfield
Clarke, Paul W	**042**	Cape Girardeau
Claseman, Wilma W	**190**	St. Louis
Clawson, James W	**082**	Springfield
***Claxton, Carl D**	**082**	Springfield
Clayton, Edgar L	**082**	Springfield
Clement, Donald J	**125**	Kansas City
Clever, Henry W	**189**	St. Charles
Clever, Victor G	**189**	St. Charles
Cline, Merle A	**125**	Kansas City
Cline, Patricia W	**125**	Kansas City
Clothiaux, Pierre L	**082**	Springfield
Clouse, John W	**082**	Springfield
Coates, James G	**002**	St. Louis
Cobb, Milton L	**190**	St. Louis

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Cochran, David S Springfield	082
Cochran, Thomas E Springfield	082
Cockerell, Charles F Blue Springs	125
Cockerell, Sanford F Independence	125
Cockrell, Steven N Hannibal	150
Codd, John E Bridgeton	190
Coe, Tracy L Joplin	102
Coffin, Helen K Shawnee Mission, KS	125
***Coffman, Avon C** Kansas City	125
***Cohen, Donald L** Kansas City	125
Cohen, Edward St. Louis	190
Cohen, Faye C Chesterfield	190
Cohen, Harry B Mexico	014
Cohen, Hillard K St. Ann	190
Cohen, Joel N Springfield	082
Cohen, Reuben J Springfield	082
Cohen, Robert S St. Louis	190
Cohn, Steven G Kansas City	125
Coin, Richard E St. Louis	190
Cokingtin, Cliff Overland Park, KS	125
Cokingtin, Diana L Kansas City	125
Cokingtin, Leovigildo C Independence	125
Colapinto, Edward V Columbia	026
Colbert, Robert S Sikeston	202
Cole, Donald E Springfield	066
Cole, Harry O Chesterfield	190
Cole, Sherman W Kansas City	125
Cole, William R Sedalia	178
Coleman, Kevin A St. Louis	190
Coleman, Matthew J Cape Girardeau	042
Coleman, Terrence W Kansas City	125
Colglazier, Mary C Lee's Summit	125
Collins, John W, Jr. Independence	125
Collison, R Michael Springfield	082
Colom, George A Kansas City	125
Colwill, Jack M Columbia	026
Comas, Manuel R St. Louis	190
Comfort, George D Mexico	014
Commerford, John F St. Charles	189
Conant, James F St. Joseph	030
Conley, Brian S Jefferson City	058
Conn, Robert D Kansas City	125
Conrad, Marshall B St. Louis	190
Contogiannis, Mary Ann C Kansas City	215
Convery, Paul B St. Louis	190
Conway, Robert R Columbia	026
Cook, James R Springfield	082
Cook, Katherine S Rolla	135
Cook, Marvin St. Louis	190
Cook, Paul R Columbia	026
Cook, Thomas B Richmond	118
Cooksey, Jon D St. Louis	190
Coonce, Don C Cape Girardeau	042
Cooper, Barry R N. Kansas City	050
Cooper, Barry J St. Louis	190
Cooper, Gary D Liberty	050
***Cooper, Glen E** Columbia	026
Cooper, Robert L, II Warrensburg	110
Cooper, Thomas J Farmington	190
Coordes, Cordie C Chesterfield	190
Coordes, Kathleen M St. Louis	190
Cope, James C Sanibel, FL	026
Copeland, Jeffrey G St. Charles	189
Copp, Ralph St. Louis	190
Coppinger, Thomas A Kansas City	125
Corcoran, Francis H Joplin	102
Corcoran, Michael J Fulton	215
Cordell, Larry D Kansas City	125
Corder, James C St. Louis	190
Corder, Patricia G St. Louis	190
Corder, Robert L St. Joseph	030
Cornwell, Karen R Kansas City	125
Corrado, Joseph A Mexico	014
Corry, Francis M Springfield	082
Corry, James M St. Louis	190
Corsolini, Thomas B Springfield	082
Cortner, Mary C Kansas City	125
Corvalan, Juan C St. Louis	190
Corwin, Kenneth D St. Louis	190
***Corzine, John J** St. Joseph	030
Coscia, Robert L Springfield	082
Costello, Joseph P, Jr. Chesterfield	190
Costen, William S Chesterfield	190
Costin, Jimmy L Poplar Bluff	034
Cotton, Thomas R Kansas City	125
Couchman, Ryan W St. Louis	190
Couper, Nicholas B Columbia	026
***Courter, Gary M** Lebanon	115
Courter, Larry P Osage Beach	058
Covarrubias, Jorge A Collinsville, IL	190
Covert, Richard A St. Louis	190
Cowden, John W Columbia	026
Cox, Curtis S Jefferson City	058
Cox, James L St. Louis	190
Cox, Jeffrey L Joplin	102
Cox, John P Amazonia	030
***Cox, John M** Joplin	102
Cox, W. Welby Springfield	082
Coxe, William S St. Louis	190
Coyne, Patrick M Bridgeton	190
Cozad, Scott C Kansas City	125
Cozean, Charles H Cape Girardeau	042
Crabtree, H. Mark Springfield	082
Cradock, Thomas V St. Louis	190
Crafts, David St. Louis	190
Craig, Alan G St. Louis	190
Craig, Richard O St. Joseph	030
Craig, Robert D St. Louis	002
Craighead, Michael L Jefferson City	058
Cram, John W Springfield	082
Cramer, Quentin Kansas City	125
Crandall, Richard E Chesterfield	190
Crane, James P St. Louis	190
Crane, John B Washington	074
***Crane, William G** Lenexa, KS	215
Cravens, David D Centralia	026
Cravens, William P Fulton	038
Craver, Jeffrey L Bridgeton	190
Crawford, Katherine J Carrollton	190
Crawford, Oral B Springfield	082
Creech, Fred T Columbia	026
Crepps, Louis F St. Louis	190
Crespin, Stephen R St. Louis	190
Crespo, Horacio T Warrenton	074
Crespo, Remedios R Warrenton	074
Creswell, Lawrence L Chesterfield	215
Crie, J. Stanley St. Joseph	030
Crighton, John C Springfield	082
Criscione, James R, Sr. St. Louis	190
Criscione, James S St. Louis	190
Criscione, James R, Jr. St. Louis	190
Crist, Roderic C Cape Girardeau	042
Critchlow, J. Thomas Cape Girardeau	042
Critchlow, Michael E Cape Girardeau	042
Critchlow, William C Sikeston	202
Crockett, James E Kansas City	125
Crockett-Maples, Melinda Springfield	082
Cronemeyer, Richard L Lee's Summit	125
Crosby, William H Joplin	102
Crotty, John P St. Louis	190
Crouch, John A Columbia	026
Croughan, Jack L St. Louis	190
Crow, Martin L Kansas City	125
***Crowell, Tamara E** Kansas City, KS	215
Crowley, William J Spicewood, TX	026
Crumpacker, Margaret St. Louis	190
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Cryer, Philip E	190	St. Louis
Cuddihee, Robert E	190	St. Louis
Culver, Perry J, Jr.	125	Kansas City
Cummings, Steven W	190	Brentwood
Cundiff, H. Clay	125	Independence
Cunningham, D. Dean	082	Springfield
Cunningham, Edwin J	190	Chesterfield
Cunningham, Milamari A	026	Columbia
Cunningham, R. Raymond	026	Columbia
Cunningham, Richard D	082	Springfield
Cunningham, William F	082	Springfield
Cupp, Gerald V	026	Columbia
Curnow, Richard B	050	Liberty
Curry, D. Troy	190	St. Louis
Curry, Michael J	189	St. Charles
Curry, Michael D	026	Columbia
Curtis, Jack J	026	Columbia
Custer, Galen M	125	Overland Park, KS
Cusumano, Joseph V	190	St. Louis
Cusworth, Robert	189	St. Charles
Cutler, Harold M	190	St. Louis
Cyriac, George K	014	Mexico
Czebrinski, Edward W	190	Chesterfield

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Daake, John W, Jr.	190	St. Louis
Daake, John W, Sr.	190	St. Louis
Dabbs, Wilbur D	166	Neosho
Dacey, Ralph G, Jr.	190	St. Louis
Dagartzikas, A K	190	St. Louis
Dahlberg, Thomas E	082	Springfield
Dahm, Charles H, Jr.	190	St. Louis
Daily, Bill B	002	St. Louis
Daily, James M	082	Springfield
Daley, Frank R	078	Hamilton
Dalton, Timothy T	125	Kansas City
Daly, James W	026	Gainsville, FL
***Daly, Michael M**	026	Columbia
Dames, Richard J	190	Chesterfield
Dandridge, Walter C	102	Joplin
Danforth, William H	190	St. Louis
Dang, Robert C	214	Pleasant Hill
***D'Angelo, James A**	215	Kansas City
Daniel, A E	026	Columbia
Daniels, John S	002	St. Louis
Danielsson, Ernst P	082	Springfield
Dankner, Arnold	190	Chesterfield
Dankner, Rand E	190	Chesterfield
Danner, Shavonne L	125	Leawood, KS
Darby, Patric J	215	Columbia
Darkow, Grant V	026	Columbia
Darmadi, Daniel H	215	Kansas City
Darnell, Dale E	125	Kansas City
Dash, Udaya N	190	Bonita Springs, FL
Dattel, F. Scott	002	Raytown
Daum, Harold F	178	Sedalia
Daus, Arthur Steven	102	Joplin
Davault, George K	118	Richmond
Davidner, Mark L	125	Kansas City
Davidson, Morris	190	St. Louis
Davidson, Raymond P	190	St. Louis
Davis, Bradley E	125	Overland Park, KS
Davis, Carl S	125	Lee's Summit
Davis, Charles S	102	Galena, KS
Davis, Donald R	125	Prairie Village, KS
Davis, Gene L	190	St. Louis
Davis, Herbert V	125	Kansas City
Davis, J. Lawrence	190	St. Louis
Davis, Jack M	125	Kansas City
***Davis, Larry E**	050	N. Kansas City
Davis, Leonard L	014	Columbia
Davis, Mary A	190	St. Louis
Davis, Michael L	215	Kansas City
Davis, Sheldon	190	Florissant
Davis, Thomas N	138	West Plains
Davis, William E	026	Columbia
Davisson, Walter F	058	Jefferson City
Davuluri, Sreenadha R	030	St. Joseph
Dean, Philip D	074	Washington
Dean, Walter E	158	Maryville
Deane, Louis V, Jr.	190	St. Louis
DeCastro, Fernando J	138	Pilot Knob
Deckard, Shelby W	082	Springfield
Decker, Albert I	082	Springfield
DeCoursey, Kenneth A	042	Cape Girardeau
DeFeo, Frederick G	125	Kansas City
DeFeo, Theodore C	125	Kansas City
***Deffenbaugh, Larry D**	102	Joplin
DeFranco, Penny E	190	Bangor, PA
DeGenova, Gerard H	174	Ste. Genevieve
DeGraff, Judith K	215	Lincoln, NE
DeGuerre, Ronald K	190	Chesterfield
Dehner, Jonathan D	190	St. Louis
Dehner, Louis P	190	St. Louis
Deisher, David M	042	Cape Girardeau
***Delaney, Adrain J, Jr.**	125	Kansas City
Delcambre, Marie A	125	Kansas City
deLeeuw, Karel A	082	Springfield
Deleste, Carlos J	106	Festus
Deligeorges, John	050	Kansas City
Dell, Robert V	150	Hannibal
Dembinski, David R	125	Kansas City
Dement, Oman E	102	Joplin
Demmy, Todd L	026	Columbia
Dempsey, Herbert A	125	Lee's Summit
***Dempsey, Herbert E**	125	Lee's Summit
Dempsey, Kenneth J	202	Sikeston
Dempsey, Maureen E	026	Columbia
Denes, Bela	190	Bridgeton
Denk, Alan F	190	St. Louis
Denninghoff, James C	026	Columbia
Denninghoff, James S	026	Columbia
Desio, Marcus A	102	Joplin
Dettmer, Robert F	138	Ironton
Devabhaktuni, Rama Devi	190	Chesterfield
Dever, Robert L	102	Joplin
Devine, Mark W	050	N. Kansas City
Devineni, V. Rao	190	Bridgeton
Devins, George S	125	Kansas City
Devkota, Jagadishwar	026	Columbia
Dew, Thomas A	190	Chesterfield
Dewald, Paul A	190	St. Louis
Dewein, Edward G	190	St. Louis
Dexheimer, Frank R	026	Columbia
Dexter, J. Kent	082	Springfield
Dexter, James D	026	Columbia
DeLine, Jim	046	Macon
Del Pizzo, Ferdinand	189	St. Charles
Del Priore, Lucian V	002	St. Louis
Del Rosario, John E	190	St. Louis
***DeLucia, Joseph A**	206	West Plains
Del Santo, Peter B	026	Columbia
Del Valle, Fernando	190	Margate, FL
DeMotte, Jeanne M	118	Richmond
DePriest, Michael D	030	St. Joseph
DeSilva, Ananda	190	Hazelwood
DeSpain, John D	026	Columbia
DeUngria, Pablo C	190	Bridgeton
DeVera, Anson E	190	St. Louis
Dick, M. Marga	026	Ashland
Dickerson, Malcolm J	058	Eldon
Diehl, Elizabeth W	190	St. Louis
Diemer, David P	190	St. Louis
Diemer, Peter A	190	St. Louis
Dierberg, Dale F	074	Chesterfield
Dierenfeldt, William T	215	Blue Springs
Dierker, Harry D	026	Columbia
Diestelhorst, James A	190	St. Louis

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Dieterich, Russell B	St. Charles	189
Dieterle, Brian D	Branson	208
DiFilippo, Emil A	St. Charles	189
Dillard, Erin M	Springfield	082
Dills, Joseph N	Springfield	082
Dilworth, Jacquelyn B	St. Louis	190
Dimayuga, Nestor G	Mansfield	206
Dinkins, James A	Cape Girardeau	042
DiPasco, Donald J	St. Louis	190
Ditmore, Q. Michael	Columbia	026
***Ditzel, Douglas W**	Joplin	102
Dix, Patricia M	Springfield	082
Dixon, Druery J	West Plains	206
Dixon, G. David	Kansas City	125
Dixon, John R	Brookfield	078
Dlabal, Luke J, Jr.	Independence	125
Dmytryk, Eugene T	St. Louis	190
Doan, Laura B	Raytown	125
Dobyan, Dennis C	St. Joseph	030
Dodge, Philip R	St. Louis	190
Dodson, Jack M	Jefferson City	058
Doerhoff, Adelia L	Jefferson City	058
Doerhoff, Alan R	Jefferson City	058
Doerhoff, Carl R	Jefferson City	058
Doerr, Dale E	St. Louis	190
Doisy, Philip P	St. Louis	190
Dolan, Patrick H	St. Louis	190
Domann, Darrel D	Springfield	082
Dominquez, Jose M	Springfield	082
Domke, Henry F	New Bloomfield	058
Donahoe, James L	St. Louis	190
Donati, Robert M	St. Louis	190
Donnell, Harold E	De Soto	106
Donnell, Robert H	Crystal City	106
Donnell, William S, Jr	Bolivar	066
Donovan, John F	St. Louis	190
Donovan, Thomas J	St. Louis	190
Dorsch, Ervin H	Independence	125
Dorton, Robert K	St. Louis	190
Dorzab, Linda L	Raytown	125
Dorzab, William E	Raytown	125
Dos Santos, Enrique	Columbia	026
Dotson, Lori J	Boonville	026
Dougherty, Thomas M, Jr.	Gladstone	054
Dowell, George H	St. Louis	190
Downey, James W	Kansas City	125
Downey, Jon P	Cape Girardeau	042
Downs, Daniel M	Kansas City	125
Drake, Roy F	Mission, KS	125
Drake, William L, Jr.	St. Louis	190
Draney, Thomas E	Hiwasse, AR	125
***Draper, Richard E**	Cape Girardeau	042
Dreher, Richard L	Leawood, KS	125
Drescher, Emmett B	St. Louis	190
Dresner, Steven M	Columbia	026
Dreyer, Carl J	St. Louis	190
Dreyer, Philip V	Huntsville	046
Driks, Michael R	Kansas City	125
Driskell, Karen K	Kansas City	125
Drisko, Robert M	Kansas City	125
Druck, Norman S	Chesterfield	190
Druet, Robert L	Springfield	082
Dubin, Sol H	Independence	125
Duckett, William D	Rolla	135
Duda, Ralph J, Jr.	Springfield	082
Duemler, Robert H	Glenco	190
Duer, Mildred C	Kansas City	125
Duerksen, Joseph J	Kansas City	125
Duff, James E	Springfield	082
Duff, John A	Springfield	082
Duff, William M	Rolla	135
Dugan, Gerald F	Kansas City	125
Duick, Daniel S	Cape Girardeau	042
Duling, Gerald J	St. Charles	189
Dumadag, Virgilio P	St. Louis	190
DuMont, Clement C	St. Joseph	030
DuMonteer, Gary	Washington	074
DuMontier, Alan J	Chesterfield	190
Duncan, David T	Wentzville	189
Duncan, Douglas M	Springfield	082
Duncan, William H	Naples, FL	125
Dunfield, Jay A	Kansas City	125
Dunlap, Patrick S	Joplin	102
Dunn, Charles W	Springfield	082
Dunn, Robert C, Jr.	St. Louis	190
***Dunn, Roxanne M**	Wathena, KS	030
Dunshee, Robert E	Maryville	158
Durel, Justin H	St. Louis	190
Durnell, Monaford D	Lee's Summit	125
Durr, Jon W	Florissant	190
Durrie, Daniel S	Kansas City	125
Dusek, Dennis A	St. Louis	190
Dwyer, Frank X	Prairie Village, KS	125
Dwyer, James G	St. Louis	190
Dye, Jennifer A	Springfield	082
Dyer, Curtis W	Warrensburg	110
Dyer, Dallas J	St. Louis	190
Dyer, Gary A	St. Joseph	030
Dysart, Dorsey W, Jr	Springfield	082

E

Eachempati, Uma R	Arnold	190
Eades, Joseph W	Chesterfield	190
Early, Gerald L	St. Joseph	030
Earnest, James B	Kansas City	125
Eaton, Paula	Kansas City	125
Eberle, Vincent L	St. Louis	190
Eck, Birkle	St. Louis	190
Eckenrode, James F	Columbia	026
Ecker, Desider B	Sun City Ctr, FL	190
Eckert, Clarence T	Longboat Key, FL	190
Edele, Eugene H	St. Louis	190
Edelman, Alan H	St. Louis	190
Edelman, Kent J	Joplin	102
Edmisten, Jack	Nevada	125
Edwards, David R	Sedalia	178
Edwards, Dean A	Cape Girardeau	042
Edwards, James E	St. Louis	190
Edwards, Ryan K	Sedalia	178
Edwards, Theodore F	Kansas City	050
Efstathianos, Kimon	Belleville, IL	190
Egan, Thomas F	St. Louis	190
Egbert, Robert N	Springfield	082
Eggers, George W, Jr.	Columbia	026
Eggleston, Harry C	St. Louis	190
Eggleston, Thomas F	St. Louis	190
Ehrlich, Carl F	St. Louis	190
Eidelman, Jack R	St. Louis	190
Eisemann, Gustave	Kansas City	125
Eisen, Arthur Z	St. Louis	190
Eisenbeis, John F	St. Louis	190
Eisenberg, Steven B	Chesterfield	190
Eisenmann, Benj P	New Haven	074
Ekern, H. Peter	Mexico	014
Ekunno, Josiah O	St. Louis	190
Elcock, Devera M	St. Louis	190
Eldenburg, Donald O	Sedalia	178
***Eldenburg, Steven C**	Sedalia	178
Elfrink, Melanie Eden	Marshall	198
Elfrink, Roy J	Marshall	198
Elias, David J	Lake Tapawingo	125
Eliasson, Sven G	St. Louis	190
***Ellefsen, Brian K**	Carthage	102
Eller, Gordon W	Cape Girardeau	042
Ellfeldt, Howard J	Kansas City	125
Elliott, Raymond G	Shawnee Mission, KS	125
Elliott, Timothy H	Kansas City	215
Elliott, Wendell H	Poplar Bluff	034

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Ellis, Francis J	082	Springfield
Ellis, Harry L	082	Springfield
Ellis, Jean H	125	Blue Springs
Ellis, John C	125	Independence
Ellis, Ronald L	082	Springfield
Ellis, Stephen C	125	Independence
Ellsasser, James C	026	Rocheport
Elser, Otto H	125	Independence
Elwing, Terry J	026	Columbia
Ely, Norman B	082	Springfield
Emanuel, James P	190	St. Louis
Emeran, George J	190	St. Louis
Emerson, William A	190	St. Louis
Emons, Matthew F	190	Louisville, KY
Engelhardt, Robert C	034	Poplar Bluff
Engels, John T	002	St. Louis
Enriquez, Roman S	125	Kansas City
***Entrup, Mark H**	082	Springfield
Eppright, Thomas D	026	Columbia
Epstein, Beverly	166	Mt. Vernon
Ernst, Edwin C, III	190	St. Louis
Ernst, Edwin C, Jr.	190	St. Louis
Ernst, Joseph G	190	St. Louis
Ernst, Richard E	190	St. Louis
Ernst, Roland P	190	St. Louis
Ervin, John E	125	Kansas City
Esch, John G	102	Joplin
Escoffery, Richard F	190	Florissant
Esguerra, Eden M	102	Joplin
Espaillat, Jose A	202	Sikeston
Esparrago, F R	166	Monett
Essah, Paulina A	215	Kansas City
Esther, John R	102	Joplin
Esther, John W	082	Springfield
Estrem, Scott A	026	Columbia
Ethirajan, Sukumar	125	Kansas City
Ettelson, Charles D	190	Chesterfield
Eubank, David F	125	Lee's Summit
Eubank, William Y	125	Leawood, KS
Evans, Andrew L	082	Springfield
Evans, Ezra L	082	Springfield
Evans, Joseph C, Jr.	125	Independence
Evans, Lawrence G, Jr.	190	St. Louis
Evans, Maria L	026	Columbia
Evens, Ronald G	190	St. Louis
Evenson, Curtis C	082	Springfield
Eversoll, Norton J	190	Ft. Lauderdale, FL
Ewing, Lesley L	125	Kansas City
Ewy, Marvin F	026	Columbia
Exon, C S	058	Jefferson City

F

Fabito, Daniel C	190	St. Louis
Faddis, Mitchell N	215	St. Louis
Fagan, Leonard F, Jr.	190	St. Louis
Fahrner, Mari A	190	Chesterfield
Fair, William L	078	Chillicothe
Fakhoury, Donald A	050	Kansas City
Fallon, Richard H	190	St. Louis
Falzone, John J	058	Jefferson City
Farber, Barry S	082	Springfield
Farberman, Elliott	190	Florissant
***Farley, Gary W**	190	St. Louis
Farmer, Norma D	138	Farmington
Farnham, Milo M	125	Independence
Farrar, Michael W	125	Merriam, KS
Farrell, John S	190	Bridgeton
Farrell, Sammy L	074	Washington
Farrell, Thomas M	002	St. Louis
Farthing, Gene W	082	Springfield
Faruqi, Sohaib A	138	Potosi
Fast, Robert E	030	St. Joseph
Faszholz, Mark S	190	Chesterfield
Fathman, Anthony E	190	Chesterfield
Faulkner, C. Byron	082	Springfield
Favors, Adolphus C, Jr.	190	St. Louis
Fedor, Barbara A	082	Springfield
Fedotin, Michael S	125	Kansas City
Fee, Chester F	125	Fairway, KS
Feit, Robert M	190	St. Louis
Feliciano, Wilfrido C	190	Maryland Heights
Felker, J. Russell	042	Cape Girardeau
Feller, Harold H	190	Chesterfield
Ferber, Alan J	125	Kansas City
Ferguson, Edward W	215	Clayton
Ferguson, John P	082	Springfield
Ferguson, John F	082	Springfield
Ferguson, John L	082	Springfield
Ferguson, Robin L	215	Blue Springs
Ferguson, Thomas B	190	St. Louis
Fernandez, Fernando	030	St. Joseph
Ferneau, James E	026	Columbia
Ferns, Francis E	125	Kansas City
Ferrara, Robert P	190	St. Louis
Ferrari, Herbert A	190	St. Louis
Ferris, Charles W, Jr.	190	St. Louis
Fibuch, Eugene E	125	Kansas City
Figueroa, Eliseo O	190	St. Louis
Fingert, Hyman H	190	St. Louis
Fink, Leroy L	190	St. Louis
Fink, Roger L	082	Rogersville
Finkel, Barney W	190	N. Ft. Myers, FL
Finn, Murray E	190	St. Louis
Finnegan, Joseph V	190	St. Louis
Fischbein, Lewis C	190	St. Louis
Fischer, Edward H	050	Gladstone
Fischer, Heidi	215	St. Louis
Fischer, John R	190	Hermann
Fischer, Robert	190	St. Louis
Fisher, James K	125	Kansas City
Fisher, Jos L	030	St. Joseph
***Fisher, Robert B**	026	Columbia
Fishman, Norman	190	Chesterfield
Fitch, Coy D	190	St. Louis
Fitz, John R	138	Farmington
Fivian, Gerald J	190	St. Louis
***Flanagan, Laura M**	215	Olathe, KS
Flance, Israel J	190	St. Louis
Fleer, Gerald K	189	St. Peters
Fleming, Allan R	125	Kansas City
Fleming, David A	046	Moberly
Fleming, J. Will, Jr	046	Moberly
Fleming, Robert J	189	St. Charles
Fleshman, James W	190	St. Louis
Fletcher, Dale M	002	St. Louis
Fletes, James W	190	St. Louis
Flicker, Michele R	125	Kansas City
Florence, Kerry E	074	Washington
Florendo, Federico N	150	Hannibal
Florendo, Purificacion T	150	Hannibal
Flores, Jhonson E	190	St. Louis
Floro, Mariano N	190	Florissant
Flotte, Sylvester A	190	St. Louis
Floyd, Marla J	082	Springfield
Flug, Eric J	190	St. Louis
Flury, Kirk E	190	St. Louis
Flynn, James M	125	Shawnee Mission, KS
Fogartie, James E, Jr.	050	Kansas City
Fogarty, William M, Jr.	190	St. Louis
Fogel, Steven T	190	Chesterfield
Fogle, Philip R	082	Springfield
Folck, William P	125	Kansas City
Foley, Jonathon K	042	Cape Girardeau
Folkner, Albert L	110	Warrensburg
Foote, Daniel D	082	Springfield
Foote, Jerry E	026	Columbia
Forand, Joseph M	190	St. Louis
Ford, Lee T	190	Belleville, IL

Ford, Thomas E	190	Niagara Falls, NY
Foreman, Phillip B	150	Hannibal
Forgue, Donald R	125	Kansas City
Forman, Louis H	125	Shawnee Mission, KS
Forsman, Karen E	190	St. Louis
Forsman, Waldo W	190	St. Louis
Forsyth, B. Todd	190	St. Louis
Forsythe, Lees C	125	Shawnee Mission, KS
Forsythe, Robert W	125	Prairie Village, KS
Fortin, Don G	050	Kansas City
Fortin, Jorge A	135	Rolla
Fortuna, Randall S	215	St. Louis
Foss, Jonathan M	190	St. Louis
Foster, R. Steve	178	Sedalia
Fouts, Dallas B, Sr.	125	Lee's Summit
Fowler, Fred D	125	Kansas City
Fowler, I. Charles	050	Kansas City
Fowler, James W	125	Leawood, KS
Fowler, Marvin L	206	West Plains
Fox, Gerald E	030	St. Joseph
Fox, Robert E	190	Chesterfield
Fox, Thomas J	190	St. Louis
Francel, Thomas J	002	St. Louis
Francis, Roger A	120	Linn Creek
Francisco, Clarence B	125	Shawnee Mission, KS
Francisco, Dominic S	190	St. Louis
Franey, Michelle R	125	Kansas City
Frank, Gael R	125	N. Kansas City
***Frank, Robert A**	125	Independence
Fraser, Daniel M	190	St. Louis
Fraser, Victoria J	190	St. Louis
Frawley, Thomas F	190	Chesterfield
Frazier, Robert E	026	Columbia
Frazier, Robert L	202	Sikeston
***Frederick, Mark R**	058	Jefferson City
Frederick, Raymond O	190	St. Louis
Frederickson, Neil W	190	St. Louis
Frederickson, Thomas W	215	Prairie Village, KS
Freedman, Ruth S	190	St. Louis
Freeman, James A	026	Columbia
Freeman, Jerry C	125	Kansas City
Freeman, Michael R	042	Cape Girardeau
Freilich, Brad L	125	Kansas City
Freiman, Paul C	082	Springfield
Frein, Donald E	214	Harrisonville
Freund, William L	125	N. Kansas City
Frevert, Larry F	125	Kansas City
Frewin, Paul R	082	Springfield
Frey, Jeffrey P	026	Columbia
Fried, John S	125	Overland Park, KS
Friedman, Ira J	074	Washington
Friedman, Michael J	026	Columbia
Friedman, Morris L	125	Shawnee Mission, KS
Friedman, William H	190	St. Louis
Friedrich, Anthony P	190	St. Charles
Friend, T. Gregory	125	Kansas City
Fries, John W	190	St. Louis
Friesen, Randall G	189	St. Charles
Fritsch, Andrew J	102	Joplin
Fritzlen, Thomas J	125	Overland Park, KS
Froehlich, Thomas W	082	Springfield
Frogge, Jim D	102	Joplin
Frohman, Boris	202	Sikeston
Fromme, Glenn A	082	Springfield
Frumson, Guy H	190	Florissant
***Fry, John M**	082	Springfield
Fryer, Dorothy S	190	St. Louis
Fu, Anna L	190	St. Louis
Fuchs, George J	026	Columbia
Fuhrman, Donald L	125	Leawood, KS
Funsch, Robert E	190	St. Louis
Furla, August J	190	St. Louis
Fusselman, Jon M	082	Springfield

G

Gabel, Michael G	190	St. Louis
Gafarian, Kathleen	082	Springfield
Gaffney, Laura A	215	Kansas City
Gafford, Franklin H, IV	190	St. Louis
Gagliardo, Joseph	190	St. Louis
Gahn, Richard S	002	St. Louis
Gaines, Robert W	026	Columbia
Gainor, Barry J	026	Columbia
Gaitonde, Mangesh R	026	Lee's Summit
Galakatos, Andrew E	190	St. Louis
Galant, Mark R	125	Belton
Galblum, Larry I	125	Kansas City
Galbraith, Polly M	125	Kansas City
Galbreath, Ashford M, Jr.	125	Kansas City
Gale, Arthur H	190	St. Louis
Gall, Ira C	190	St. Louis
Gallemore, Rex A	102	Neosho
Gallion, Terry L	125	Prairie Village, KS
Galvez, Sisenando P	078	Marceline
Gambill, Gary L	190	Chesterfield
Gamboa, Edgardo C	030	St. Joseph
Gandhi, Sanjiv K	215	St. Louis
Gans, Lawrence A	190	Florissant
Gantz, John A	190	St. Louis
Garcia, Delia M	190	St. Louis
Garcia, Eduardo L	190	St. Louis
Garcia, Kathleen M	190	St. Louis
Garcia-Ferrer, Eduardo A	190	Key Biscayne, FL
Gardner, Joe A	102	Joplin
Gardner, Joseph W	166	Kimberling City
Garfinkel, Bernard T	190	St. Louis
Garner, Royal S	058	St. Petersburg, FL
Garrard, Jacqueline M	190	St. Louis
Garrett, Ted E	190	St. Louis
Garrett-Hunt, Christi J	215	Kansas City
Garriga, Francisco J	190	Florissant
Garrison, David L	030	St. Joseph
Garrison, Roy F	125	Kansas City
Garrison, Theodore W	120	Camdenton
Garrotto, Lewis J	026	Columbia
Garvin, Charles F	190	St. Louis
Gassman, Ann A	125	Kansas City
Gaston, David A	215	Columbia
Gatapia, Ramilo I	215	Kansas City
Gatchalian, Felicitas Z	190	St. Louis
Gates, Mark L	042	Cape Girardeau
Gauer, Robert J	050	Kansas City
Gaul, Cpt., Mark P	135	Ft. Leonard Wood
Gauthier, Charles P	125	Kansas City
Gavankar, Sharad S	102	Joplin
Gavini, Rajendra R	190	St. Louis
Gay, John W	026	Columbia
***Gayle, David R**	034	Piedmont
***Gayle, Richard E**	034	Piedmont
Gearhart, Wilbur H	190	Chesterfield
Gedney, William B	190	Valley Park
Gehm, Louis E	214	Butler
Gehrs, Karen M	125	Kansas City
Geier, David L	082	Springfield
Geise, August W	190	St. Louis
Geisman, Richard A	189	St. Peters
Geisse, Guillermo	190	St. Louis
Gelberman, Richard H	190	St. Louis
Geller, Bruce D	125	Kansas City
Gellman, Elliot F	190	St. Louis
Gelstein, Laurence D	190	St. Louis
Gendel, Jonathan	125	Lee's Summit
Gennaoui, Jad M	190	St. Louis
Gentry, Michael A	082	Springfield
Gentsch, Kenneth W	190	St. Louis
Genzlinger, Jeffrey L	215	Kansas City
Geraghty, Thomas E	125	Kansas City
Gerdes, John A	082	Springfield

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Gerdes, K. Eric	082	Springfield
German, David S	190	St. Louis
German, Walter A	082	Springfield
Germann, Donald R	125	Shawnee Mission, KS
Gernstetter, S L	034	Poplar Bluff
Gerowin, Lance	190	St. Louis
Gerst, Aloysius C	190	St. Louis
Gessler, James A	082	Springfield
Geter, Rodney K	082	Springfield
Ghazal-Albar, Naman	150	Louisiana
Ghosh, Nellie	190	St. Louis
Ghosh, Sanjay	074	Washington
Giangiacomo, Joseph	026	Columbia
Gibbons, James J	190	St. Louis
***Gibbons, Jerry L**	190	St. Louis
Gibbons, Robert T, Jr.	125	Overland Park, KS
Gibson, David M	125	Santa Fe, NM
Gibson, James D	082	Springfield
Gibson, Merlyn D	026	Columbia
Gibson, Paul H	190	St. Louis
Gibson, William P	190	Chesterfield
Giddings, Frank C	082	Springfield
Gieselmann, James W	034	Poplar Bluff
***Giffen, Lawrence E**	058	Jefferson City
Gigantelli, James W	026	Columbia
Gilbirds, William M, II	050	Kansas City
Gilden, Jerome J	190	St. Louis
Gill, Paul J	082	Springfield
Gillbanks, Marjon M	125	Independence
Gilliland, Craig	002	Kansas City
Gilula, Louis A	190	St. Louis
Gimpelson, Richard J	190	Chesterfield
Ginardi, Donald E	125	Kansas City
Ginsberg, B. William	125	Kansas City
Ginther, James W, Jr.	190	St. Louis
Giorgi, Lee V	125	Kansas City
Gish, E R	038	Fulton
Givler, Robert L	125	Kansas City
Glaser, Larry F	125	Cleveland
Glass, William J	166	Nixa
Glazer, Harvey S	190	St. Louis
Glazer, Melvin L	125	Kansas City
Glazzard, Charles D	082	Springfield
Glenn, Edward A	150	Louisiana
Glenn, Theodore J	042	Cape Girardeau
Glenski, James A	125	Kansas City
Glines, Michael H	190	Arnold
Glover, David	110	Warrensburg
Glueck, Robert M	125	Kansas City
Gnade, Albert J	190	St. Louis
Gnatz, Steven	026	Columbia
Godlewski, Krystof J	125	Kansas City
Godwin, Lehman W	082	Springfield
Goebel, Joan M	190	St. Louis
Goebel, Joel A	190	St. Louis
Goeking, C. Keith	030	St. Joseph
Goff, John E	102	Joplin
Goheen, John R	125	Kansas City
Gold, Jonathan A	190	St. Louis
Goldberg, Joseph P	125	Overland Park, KS
Goldman, Arnold M	190	St. Louis
Goldman, Barry C	125	Kansas City
Goldman, Gordon M	190	St. Louis
Goldman, Stanley L	125	Shawnee Mission, KS
Goldring, Sidney	190	St. Louis
Goldsich, Edward	125	Kansas City
Goldstein, David E	026	Columbia
Goldstein, Marcy A	002	St. Louis
Goler, Michael R	082	Springfield
Goltschman, John P	190	Florissant
Gomez, Cesar A	190	St. Louis
Gomez, Patrick L	082	Springfield
Gondring, William H	030	St. Joseph
Gonzales, Jose H	174	Perryville
Gonzalez, Alicia D	190	St. Louis
Gonzalez-Pina, Roberto	202	Sikeston
Good, Michael W	082	Springfield
Good, Thomas H	125	Kansas City
Goodenberger, Daniel M	002	St. Louis
Goodhope, Karen F	190	St. Louis
Goodman, Douglas E	082	Springfield
Goodman, Gary M	190	Chesterfield
Goodwin, J. Wendall	082	Springfield
Gordon, Bruce J	026	Columbia
Gordon, Glenn L	014	Mexico
Gordon, James M	190	Florissant
Gordon, James S	058	Sedalia
Gordon, Mark E	050	N. Kansas City
Gose, Don F	082	Springfield
Gosek, Marek J	110	Warrensburg
Gottsch, Joseph C	125	Shawnee Mission, KS
Gould, Ronald J	190	St. Louis
Gowda, Manohar Sai	215	Kansas City
Gowdamarajan, Rengasamy	125	Kansas City
Grable, James D	042	Cape Girardeau
Grace, Steve	082	Springfield
Grady, Ronald K	190	Chesterfield
***Graessle, Donna M**	125	Kansas City
Graham, Bruce D	125	Shawnee Mission, KS
Graham, Joseph E	190	St. Louis
Granberg, Steven J	215	St. Louis
Grand, M. Gilbert	190	St. Louis
Grant, John M	190	St. Louis
Grant, Laura L	026	Columbia
Grant, Mark	026	Columbia
Grant, Neville	190	St. Louis
Grant, Ruth	082	Springfield
Graul, Walter P	190	St. Louis
***Graven, Timothy G**	106	Festus
Graviss, E. Richard	190	St. Louis
Gray, Gary J	190	St. Louis
Grebe, T. Keith	102	Joplin
Greehus, John J	138	Farmington
Greditzer, Harry G	190	St. Louis
Green, J. Richard	125	Independence
Green, Morton R	190	Belleville, IL
Green, Thomas F	125	Independence
Green, William R	190	St. Louis
Greenberg, Jeffrey A	102	Joplin
Greene, Harry L	150	Tucson, AZ
Greene, Howard G	150	Louisiana
Greene, Walter B	026	Columbia
Greenlaw, Cal W	078	Chillicothe
Greenlund, Nelson C	214	Nevada
Greenspan, Aaron B	215	St. Louis
***Greenspan, Peter B**	125	Independence
Greenwald, James E	190	St. Louis
***Greer, Sam T**	102	Joplin
Gregory, Mark H	190	St. Louis
Gregston, J. Leon	082	Springfield
Gresick, Robert J, Jr.	190	St. Louis
Gresick, Robert J	190	St. Louis
Griesbaum, Robert V	190	St. Louis
Griesemer, Bernard A	082	Springfield
Griffin, Darrell L	138	Farmington
Griffin, Donald R	002	Kansas City
Griffin, M E	066	Springfield
Griffin, William T	026	Columbia
Griffith, S Kent	042	Cape Girardeau
Grillot, Michael B	082	Springfield
Grim, Edward M	102	Joplin
Grimes, Manning E	030	St. Joseph
Grimes, R. Alan	215	Kansas City
Grimm, Mark E	082	Springfield
Grimm, Mary T	190	Florissant
Grisham, Thomas D	074	Washington
Groce, George D	038	Fulton
Groshong, Ted D	026	Columbia

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Grossberg, George T	190	St. Louis
Grubb, Robert L, Jr.	190	St. Louis
Grunt, Jerome A	125	Kansas City
Guastello, Joseph R	125	Kansas City
Guastello, Mario J	125	Kansas City
Gubin, Barry A	125	Kansas City
Guerra, Gaston G	125	Kansas City
Guhleman, Henry V	058	Jefferson City
Guillaume, Carole A	215	Kansas City
Gujarati, Subhash B	034	Poplar Bluff
Gulick, C. Richard	190	St. Louis
Gum, Patricia A	215	Belton
Gunderson, Jeffrey K	082	Springfield
Gundle, Sigmund	125	Prairie Village, KS
Gunn, Jack	120	Versailles
Gunn, Richard W	125	Kansas City
Gunn, Victoria	058	Jefferson City
Gunn, Walter T	190	St. Louis
Gunnoe, Robert E	125	Kansas City
Gunter, Joe S	030	Lake Ozark
Gunter, Kevin G	178	Sedalia
Gupta, Nilakshi	026	Columbia
Gurba, Carol L	125	Kansas City
Gurba, Danny M	125	Kansas City
Gurian, Lawrence E	082	Springfield
Gurucharri, Vincent P	026	Columbia
Gustafson, Jon E	125	Lee's Summit
Gutek, E. Philip	125	Kansas City
Gutierrez, Anthony C	125	Kansas City
Gutierrez, Ernesto	190	Florissant
Gutknecht, Richard	125	Independence
Guy, Cynthia S	190	St. Louis
Guyer, Emily	026	Columbia
Guyol, William B, Jr.	190	St. Louis
Guze, Samuel B	190	St. Louis
Gwin, Edward	082	Springfield

H

Ha, Richard J	150	Hannibal
Haake, Gregory K	082	Springfield
Haas, Robert W	050	Liberty
Habermann, James H	102	Joplin
Habert, Edward R	190	Chesterfield
Habib, Henry N	120	Sterling, VA
Hacker, Douglas A	082	Springfield
Hackett, Earl R	082	Springfield
Haddock, James N	190	St. Louis
Haddow, Alastair D	082	Springfield
Hagan, John C, III	050	N. Kansas City
Hagemann, Margarethe H	190	St. Louis
Hagemann, Paul O	190	St. Louis
Hagen, Douglas W	125	Kansas City
Hagen, Duane Q	190	St. Louis
Hagen, Garrett A	190	St. Louis
Hahn, Bruce H	125	Lee's Summit
Hahn, Frederick W	125	Independence
Hahn, Yoram	190	Florissant
Haight, J. Max	125	Kansas City
Haith, Walter F	125	Kansas City
Halberstadt, Cathanie W	125	Kansas City
Hale, Thomas H	190	Manchester
Halford, Richard M	190	St. Louis
Hall, Bryan K	082	Springfield
Hall, David W	082	Rogersville
Hall, David G, III	026	Rocheport
Hall, Deborah M	125	Overland Park, KS
Hall, Durward G	082	St. Petersburg, FL
Hall, John C	125	Kansas City
***Hall, John P**	042	Cape Girardeau
Hall, Robert T	125	Kansas City
Hall, Stanley G	150	Hannibal
Hall, Terry E	078	Bethany
Halloran, Mark J	190	St. Louis
Halpin, Stephen E	150	Hannibal
Halsted, Robert W	074	Washington
Halsted, Teresa M	074	Washington
Halverson, Larry W	082	Springfield
Hamburg, Eric D	138	Farmington
Hamel, Peter C	150	Hannibal
Hamid, Rashid S	198	Marshall
Hamid, Zahid	158	Mound City
Hamill, Robert W	125	Gulfport, FL
Hamilton, Caldwell K	190	St. Louis
Hamilton, Eugene G	190	St. Louis
Hamilton, William P	166	Aurora
Hamilton, William P	190	St. Louis
Hammerman, Marc R	190	St. Louis
Hammond, D. Wade	190	St. Louis
Hamre, Daniel W	082	La Grande, OR
Hanaway, Joseph	190	St. Louis
***Hancock, Thomas J**	058	Jefferson City
Handler, Fred P	058	Clayton
Handler, Michael R	190	St. Louis
***Handlin, Larry R**	014	Mexico
Hanes, Lily A	190	Golden Eagle, IL
Hanks, Michael S	082	Springfield
Hanley, Thomas P	190	St. Louis
Hanna, Hugh A	110	Warrensburg
Hannah, Hamner, III	125	Prairie Village, KS
Hannas, Ralston R	125	Kansas City
Hansbrough, Eugene T	034	Poplar Bluff
Hansen, Thomas L	125	Independence
Hanson, E J	125	Kansas City
Hanson, Jason M	215	Valley Park
Hanson, Karl H	125	Kansas City
Hantz, Oscar	190	Florissant
Hardacre, Ruth A	125	Kansas City
Harding, Clarke T	189	Collinsville, IL
Hardy, David A	190	St. Louis
Hardy, Guerdan	190	St. Louis
Hardy, H. Malcolm	125	Shawnee Mission, KS
Hardy, Jeffery A	190	St. Louis
Hardy, Patrick J	190	Florissant
Hardy, Samuel W	190	St. Louis
Hardy, Stanton L	138	Desloge
***Hare, Thomas**	082	Springfield
Harell, Alex	190	St. Louis
Hargis, James L	082	Springfield
Hari, Magaral S	102	Joplin
Harless, Morris S	125	Galena
Harmon, Ben C	082	Springfield
Harms, James F	214	Nevada
Harner, Casper G	030	Austin, TX
Harr, Patrick B	158	Maryville
Harris, David J	125	Kansas City
Harris, Hugh G	082	Springfield
Harris, Hugh S, Jr.	026	Columbia
Harris, Lanny W	125	Kansas City
Harris, Louis B	066	Bolivar
***Harris, William D**	125	Lenexa, KS
Harrison, Garth F	125	Kansas City
Harrison, Thomas J, Jr.	189	St. Charles
Harrison, Winston E	026	Columbia
Harshman, David M	190	St. Louis
Hart, L. Wayne	125	Shawnee Mission, KS
Hart, William M, Jr.	190	St. Louis
Hart, William G, Jr.	190	St. Louis
Hartman, James M	190	St. Louis
Hartman, Paul T	190	St. Louis
Hartman, Richard A	190	St. Louis
Hartnett, Anna E	190	St. Louis
Hartnett, Thomas D	190	St. Louis
Hartstein, Jack	190	Chesterfield
Hartwig, Frederick H	125	Kansas City
Hartwig, Raymond W	125	Kansas City
Hartzler, Geoffrey O	125	Shawnee Mission, KS
Harvey, Judith E	082	Springfield
Harwell, J. Larry	190	St. Louis

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Haskins, Robert D, Jr.	**082**	Springfield
Hassen, Mark A	**002**	St. Louis
Hassien, Joel D	**150**	Hannibal
Hata, J. Steven	**026**	Columbia
Hata, Tara M	**026**	Columbia
Hatfalvi, Bela I	**190**	St. Louis
Hatlelid, J. Michael	**190**	St. Louis
Haulard, Marcel E	**215**	St. Louis
Haupt, Herbert A	**190**	St. Louis
Hauser, Robert J	**058**	Jefferson City
Havey, John	**026**	Columbia
Havlioglu, Necat S	**215**	St. Louis
Hawatmeh, Abraham S	**190**	St. Louis
Hawatmeh, Isam	**190**	St. Louis
Hawk, Bray O	**190**	St. Louis
Hawkins, Calvin D	**082**	Springfield
Hay, Donald P	**190**	St. Louis
Haycraft, Gordon L	**042**	Cape Girardeau
Hayden, Melvin R	**120**	Camdenton
Hayek, Michael E	**190**	St. Louis
Hayes, Kimberly W	**125**	Lee's Summit
Hayes, Lawrence L	**050**	Kansas City
Hayes, Nancy J	**206**	Mountain Grove
Haynie, William W	**214**	Butler
Hazan, Joseph	**190**	Bridgeton
Hazen, Robert M	**125**	Prairie Village, KS
H'Doubler, Charles	**082**	Mt. Vernon
H'Doubler, Francis T	**082**	Springfield
H'Doubler, Peter B	**082**	Springfield
Headrick, John A	**190**	Lake St. Louis
Heath, Jimmy D	**202**	East Prairie
Hecker, Joseph E	**034**	Poplar Bluff
Hedgepeth, Bruce L	**082**	Springfield
Hedrick, Frances A	**058**	Holts Summit
Heeb, Max A	**202**	Sikeston
Hegde, S. Roy	**125**	Kansas City
Heilman, M. Kathlyne	**082**	Springfield
Heimburger, Richard A	**120**	Osage Beach
Heins, James N	**190**	St. Louis
Heinz, George	**082**	Springfield
Heise, Julie R	**125**	Liberty
Helfrich, Loring	**202**	Sikeston
Helikson, Mary A	**026**	Columbia
Hellam, Duane C	**082**	Springfield
Heller, Randall L, Jr.	**190**	St. Louis
Helling, Thomas S	**125**	Kansas City
Hellman, Richard	**125**	N. Kansas City
Hellweg, Raymond W	**190**	Florissant
Helzberg, John H	**125**	Kansas City
Hembree, Kathryn A	**050**	Liberty
Hendren, Thomas H	**050**	Liberty
***Hennan-Hain, Pearl E**	**102**	Joplin
Henry, Clarke L, Jr	**125**	Kansas City
Henry, Clarke L	**125**	Shawnee Mission, KS
Henry, Lawrence D	**058**	Columbia
Henry, Mary M	**125**	Kansas City
Henry, R. Beth	**125**	Kansas City
Henson, Bruce E	**125**	Kansas City
Herdoiza, Alfonso W	**125**	Shawnee Mission, KS
Herfkens, Kenneth D	**082**	Springfield
Herman, Robert L	**125**	Kansas City
Hernandez, J. Humberto	**074**	Gerald
Hernandez, Richard P	**138**	Cape Girardeau
Hernandez, Salvador R	**190**	St. Louis
Herrick, Thomas B	**050**	Kansas City
Herrmann, Deborah A	**198**	Marshall
Herrmann, Steven C	**215**	High Ridge
Hershey, Falls B	**190**	St. Louis
Hervey, William H	**125**	Kansas City
Herzog, Jacques A	**190**	Chesterfield
Hesker, Albert E	**190**	Chesterfield
Hess, John P	**190**	St. Louis
Hettinger, Brenda A	**120**	Camdenton
Heutel, Lee B	**190**	St. Louis
Hickey, James L	**190**	St. Louis
Hicks, Christina M	**215**	Fulton
Hicks, Frederick G	**190**	St. Louis
Hicks, Robb R, IV	**042**	Cape Girardeau
Hierholzer, Rebecca S	**125**	N. Kansas City
Higgins, Edward F, JR	**125**	Kansas City
Higgins, Michael D	**042**	Cape Girardeau
Higgins, Philip C	**190**	St. Louis
Higgs, Philip E	**190**	St. Louis
Highland, Thomas R	**026**	Columbia
Hilbert, Paul H	**190**	St. Louis
Hill, David K	**125**	N. Kansas City
Hill, Jack H	**125**	Leawood, KS
Hill, M. Robert	**190**	St. Louis
Hill, Randy C	**082**	Springfield
Hill, Ronald T	**202**	Dexter
Hill, XaCadene A	**190**	St. Louis
Hillard, Alan E	**026**	Columbia
Hills, Joe E	**082**	Springfield
Hilton, Paul E	**102**	Joplin
Himes, Joyce B	**082**	Springfield
Hinds, R. David	**026**	Columbia
Hindupur, Mohan R	**030**	St. Joseph
Hinrichs, Christian S	**215**	Kansas City
Hinrichs, James H	**190**	Bridgeton
Hintze, Paul F	**190**	Chesterfield
Hiremath, Yoganand J	**102**	Joplin
Hironimus, John E	**190**	St. Louis
Hirose, Christopher B	**215**	St. Louis
Hite, Dennis E	**115**	Lebanon
Ho, Judith E	**190**	St. Louis
Hoberock, Thomas R	**208**	Branson
Hodge, Robert H	**050**	Kansas City
Hoech, George P, Jr.	**125**	Kansas City
Hoehn, John P, III	**190**	St. Louis
Hoehner, Paul J	**030**	St. Joseph
Hoeman, Michael D	**082**	Springfield
Hoeper, Samuel D, Jr.	**125**	Kansas City
Hoeper, Samuel D, Sr.	**125**	Grandview
Hoffarth, Sharon C	**190**	St. Louis
***Hoffman, James E**	**042**	Cape Girardeau
Hoffman, Leanna M	**078**	Hamilton
Hoffman, Mark J	**190**	St. Louis
Hoffman, William F	**190**	St. Louis
Hoffmann, Alan L	**125**	Kansas City
Hoffmann, Lee M	**125**	Shawnee Mission, KS
Hoffmann, Ronald E	**190**	St. Louis
Hoffmann, Sandra S	**190**	Chesterfield
Hofmeister, Roger W	**026**	Columbia
Hofstatter, Leopold	**190**	St. Louis
Hogan, Cornelius E	**190**	St. Louis
Hogan, John R	**190**	St. Louis
***Hogan, Patricia E**	**030**	St. Joseph
Hogan, Patrick A	**190**	St. Louis
Hogan, Patrick C	**190**	St. Louis
Hoja, John M	**034**	Poplar Bluff
Hoja, W Alex	**034**	Poplar Bluff
Holand, Roy W	**082**	Springfield
Holcomb, John K	**042**	Cape Girardeau
Holder, Thomas M	**125**	Prairie Village, KS
Holds, John B	**190**	St. Louis
Holekamp, Timothy	**026**	Columbia
Holemon, R. Eugene	**190**	St. Louis
Holley, Donald B	**082**	Springfield
Hollis, Richard W	**082**	Springfield
Hollocher, Richard J	**190**	St. Louis
Holloway, Robert B	**190**	St. Louis
Holmes, David R	**082**	Springfield
Holmes, Nancy E	**190**	St. Louis
Holt, Benjamin T	**026**	Columbia
Holtmann, Barbel	**190**	St. Louis
Holton, Edward B	**125**	Independence
Holtz, Alan S	**190**	St. Louis
Holtz, Sumner	**002**	Chesterfield

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Holzem, Craig S	Washington	074
Honaas, Trygve O	Cape Girardeau	042
Honeycutt, Pamela J	Columbia	026
Hoos, Gary L	Springfield	082
Hooshmand, Ahmad	Jefferson City	058
Hoover, Bernard L	St. Louis	190
Hopkins, James P	Shawnee Mission, KS	125
Hopkins, Thomas S	Hughesville	178
Hopkins, Thomas A	Springfield	082
Hopson, David K	St. Charles	190
Horan, John J, Jr.	St. Louis	190
Horenstein, Simon	St. Louis	190
Horine, Jon A	Kansas City	125
Horn, Paul C	Cape Girardeau	042
Hornbostel, Phillip M	Sedalia	178
Horner, Charles W	Kansas City	125
Horner, John L	Chesterfield	190
Hornig, Gregory W	Kansas City	125
Hornstra, Robijn K	Kansas City	125
Horton, Bill G	Springfield	082
Horton, James D	Springfield	082
Horwitz, Irwin B	Clayton	190
Hoskins, R. Bruce	Kansas City	125
***Hosley, Brett D**	Hannibal	150
Houck, William E	Chesterfield	190
Houghton, Howard L	Kansas City	125
Houttuin, Erik	Washington	074
Hover, Alexander R	Springfield	082
Howard, Campbell P	Kansas City	125
Howard, Todd K	St. Louis	190
Howell, Billy D	Brookfield	078
Howell, David T	Florissant	002
Howitt, William J	Springfield	082
Hoxworth, Gerald M	Belle	135
Hoye, Robert C	Ste. Genevieve	174
Hrabik, Brent	Tarkio	158
Hruza, George J	St. Louis	190
Hruza, Luciann L	St. Louis	002
Hu, Raymond J	St. Peters	189
Hubbard, John D	Kansas City	125
Hubbard, Sally L	Springfield	082
Hubbell, George P	Osage Beach	120
Hubbell, Marius M, Jr.	Kansas City	125
Huber, Kenneth C	Kansas City	125
Hubert, John W	Bridgeton	190
Huck, Richard F, Jr.	St. Louis	190
Hucke, Samuel T, III	Kansas City	125
Huddleston, Charles B	St. Louis	190
Hudgens, Richard W	St. Louis	190
Hudson, Randall B	Kansas City	125
Huewe, Douglas A	Springfield	082
Huff, Kalaichelvi R	Joplin	102
Huffaker, William H	Chesterfield	190
Huffman, Larry	Branson West	208
Huggins, Albert M	St. Louis	190
Hughes, Derek	Columbia	026
Hughes, Michael F	Kansas City	125
Huguenard, Joseph R	St. Louis	190
Huk, Stephen G	Overland Park, KS	050
Hulbert, Bernard	St. Louis	190
Hulbert, Laura R	St. Louis	190
***Hull, Jeffrey F**	Kansas City	125
Hull, Timothy A	Kansas City	125
Hulstra, Johannes F	Springfield	082
Hummel, Anton J	St. Louis	190
Hummel, Gregory L	Independence	125
Humphrey, James D	Mound City	158
Humphrey, Loren J	Columbia	026
Humphrey, Paul W	Columbia	026
Humphreys, Edward T	Boonville	026
Humphreys, William	St. Joseph	030
Hunkeler, John D	Kansas City	125
Hunleth, Frank E	St. Louis	190
Hunsley, Perry U	Salina, KS	208
Hunt, Robert S	Cape Girardeau	042
***Hunter, Harlen C**	Chesterfield	190
Hunter, James K, Jr.	Fairfax	158
Hunzicker, Warren J	Kansas City	125
Hurley, Joseph J	St. Louis	190
Hurly, Michael P	Joplin	102
Huse, William J, II	Kansas City	125
Huss, Randall D	Rolla	135
Husted, Frederick C	Springfield	082
Huster, Robert M	Liberty	135
Huston, Kent A	Kansas City	125
***Hutchins, Sherry S**	Waynesville	135
Hutchinson, William B	St. Louis	190
Hyatt, Robert W	Jefferson City	058
Hyde, Lawrence L	Kansas City	125

I

Icaza, Ramiro	Jackson	042
Ide, Carl H	Columbia	026
Idstrom, Mark E	Kansas City	125
Imes, Elvin D	Columbia	026
Ingham, Walton C	Shawnee Mission, KS	125
Ingram, Donald R	Festus	190
Ingram, Ellis A	Columbia	026
Inman, Max M	Chesterfield	190
Inocentes, Fe A	O'Fallon	189
Ip, Aidan W	St. Louis	190
Ippensen, John H	Springfield	082
***Irinyi, Elmer T**	Gower	030
Irvin, William S	Columbia	026
Irvin, Wm M	St. Louis	190
Irwig, Fred	Prairie Village, KS	125
Isaac, Anita M	Springfield	082
***Isaacs, Victor E**	Scott City	042
Ishida, Yasuo	St. Louis	190
Itoku, Kendall	Chesterfield	190
Ivins, Gregory K	Fulton	038
Iwane, Akira	Chesterfield	190
Izmirlian, Grant	St. Louis	190

J

Jaax, Jeffrey D	Kansas City	125
Jablonski, Raymond C	St. Charles	190
Jackson, Dorothy J	Gladstone	125
Jackson, Jay A	Kansas City	125
Jackson, Max G	Kansas City	125
Jackson, Vernon B	Fulton	038
Jacob, Joe	Columbia	026
Jacobs, Donald L	St. Louis	002
Jacobs, Morton	Overland Park, KS	125
Jaeger, Joseph N	Jackson	042
Jafri, Syed F	Hamilton	078
Jahanian, Iraj	Springfield	082
Jain, Poonam M	St. Louis	190
Jain, Sangeeta	Jefferson City	058
Jain, Savitri G	St. Louis	190
Jain, Sumer C	St. Louis	190
Jakoby, Michael G, IV	St. Louis	215
Jamal, Ayman	Kansas City	215
James, Elizabeth J	Columbia	026
James, Kathleen M	St. Charles	189
James, Otis E	Shawnee Mission, KS	125
James, Ronald C	Columbia	026
Jameson, James E	Springfield	082
Jamroz, Greg A	Washington	074
Janeczko, Gregory F	Springfield	082
Janney, Stephen K	St. Louis	190
Jantsch, Deborah A	Kansas City	125
Jantz, Keith	Kansas City	125
Jaraki, Omar	Columbia	215
Jarka, Dale E	Kansas City	125
Jaroonwanichkul, Pairote	St. Louis	215
Jarvis, Cathy C	Florissant	190
Javdan, Ron	St. Louis	190

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*Doctor of Osteopathy

Jayamanne, Damasus S	058	Jefferson City
Jedlinski, Michael T	042	Cape Girardeau
Jeffries, Joel T	026	Columbia
Jelley, V. Carl	125	Blue Springs
Jenkins, David C	125	Kansas City, KS
Jenkins, Edward R	135	Waynesville
Jenkins, James J	190	St. Louis
Jennett, Richard B	058	Jefferson City
Jensen, Joshua E, II	190	St. Louis
Jessup, Michael J	042	Cape Girardeau
Jew, Amie C	125	Overland Park, KS
Jewell, Gregory L	002	St. Louis
Jimenez, David F	026	Columbia
Joachims, Brian V	215	Kansas City
Jobe, Charles L	082	Springfield
Johar, Ravi S	190	St. Louis
Johnson, C. L.	125	Kansas City, KS
Johnson, Charles J	190	St. Louis
Johnson, Cindi K	030	St. Joseph
Johnson, Dallas A	125	Overland Park, KS
Johnson, Earl W	042	Cape Girardeau
Johnson, Eric J	002	Chesterfield
Johnson, Frank E	190	St. Louis
Johnson, Fritz M	082	Springfield
Johnson, Gareth R	125	Independence
Johnson, Garry A	190	Des Peres
Johnson, Glen E	190	St. Louis
Johnson, Gordon L	106	Festus
Johnson, James S	125	Kansas City
Johnson, Jeffrey R	082	Springfield
Johnson, Joseph E	125	Kansas City
Johnson, Joseph C, Jr	082	Springfield
Johnson, Lent C	150	Hannibal
Johnson, Lenworth N	026	Columbia
Johnson, Patrick E	138	Farmington
Johnson, Rebecca S	125	Kansas City
Johnson, Steven M	190	St. Louis
Johnson, Thomas M	125	Shawnee Mission, KS
Johnson, Warford B, Sr	082	Springfield
Johnson, Warford B, II	082	Springfield
Johnson, Warren L, JR	125	Kansas City
Johnston, Richard	190	St. Louis
Johnstone, John T	190	St. Louis
Jolly, Ben L	014	Mexico
Jolly, Benj N	014	Mexico
Jonas, Harry S	125	Chicago, IL
Jones, Bruce N	190	Chesterfield
Jones, Dwayne E	125	Kansas City
Jones, Edward S	214	Overland Park, KS
Jones, Gale O	125	Kansas City
Jones, Georgia A	190	St. Louis
Jones, Gordon	202	Sikeston
Jones, Harold L	082	Springfield
Jones, Jeffrey T	102	Joplin
Jones, Justin E	014	Mexico
Jones, Laird E	082	Springfield
Jones, Lowry, Jr.	125	Kansas City
Jones, Maynard C, Jr.	125	Lee's Summit
Jones, Michael D	014	Mexico
Jones, Paul S	102	Joplin
Jones, Randall W	125	Independence
Jones, Richard A	190	St. Louis
Jones, Robert P	125	Blue Springs
Jones, Robert W	206	West Plains
Jones, Robert R	214	Nevada
Jones, Robin R	026	Columbia
Jones, T. Reid	125	Prairie Village, KS
Jones, Timothy R	190	St. Louis
***Jordan, Earl L, Jr**	102	Joplin
Jordan, Janet C	082	Springfield
Jorgensen, Eric D	026	Columbia
Joseph, Harold J	190	St. Louis
Joshi, Surekha K	190	St. Louis
Joslyn, Harold L	190	Mt Vernon, IN
Jost, Charles A	190	N. Ft. Myers, FL
Jotte, Richard P	190	St. Ann
Jotte, Richard F	190	St. Louis
***Joubert, Paul M**	125	Lee's Summit
Joyce, Steven T	125	Kansas City
Judd, Donald R	190	St. Louis
Judd, Jeffrey B	190	St. Louis
Judge, Steven J	074	Washington
Judy, Joseph D	026	Beloit, WI
Juergens, William G	190	St. Louis
Julien, Rene	190	Belleville, IL
Jung, Christopher H	042	Cape Girardeau
Jung, J. Marshall	042	Cape Girardeau
Junker, James A	106	St. Louis
Justus, John B	125	Shawnee Mission, KS

K

Kahn, Joseph A	189	St. Charles
Kaigh, Jodi	135	Rolla
Kairuz, Bartolome C	190	St. Louis
Kaiser, George C	190	St. Louis
Kakaiya, Dilip H	070	Kennett
Kallenbach, Glen P	014	Mexico
Kamakas, Nicholas C	190	St. Louis
Kamath, K.P.S.	042	Cape Girardeau
Kamenetzky, Stephen A	190	St. Louis
Kanagawa, Harold K	058	Jefferson City
Kanarek, Joseph	125	Kansas City
Kang, Juan	190	St. Louis
Kang, Young M	206	West Plains
Kanlie, Enes M	135	Rolla
Kanne, Marty A	050	Kansas City
Kantor, Julius M	125	Mission Hills, KS
Kantor, Owen	190	St. Louis
Kantor, Samuel	125	Englewood, CO
Kaplan, Henry J	190	St. Louis
Kaplan, Michael F	026	Columbia
Kapp, Dave	174	Perryville
Kapp, Mary Beth	042	Cape Girardeau
Kapp, William K, III	042	Cape Girardeau
Kappesser, Netajean G	190	St. Louis
Kappesser, Roland C	190	St. Louis
Kardesch, Milton	190	St. Louis
Karges, Melvin D	125	Kansas City
Karl, Michael M	190	St. Louis
***Karr, Jerry L**	042	Cape Girardeau
Karraker, Alvan G	138	Farmington
Karsh, Robert S	190	St. Louis
Kartus, Irving	125	Shawnee Mission, KS
Kase, James B, Jr.	125	N. Kansas City
Kass, Michael A	190	St. Louis
Kasten, Mark C	042	Cape Girardeau
Kasten, Melvin C	042	Cape Girardeau
Kaster, Steven D	125	Kansas City
Katf, Nicola Y	050	N. Kansas City
Katsantonis, George	190	St. Louis
Kauffman, Ruth	120	Versailles
Kaufman, Andrew B	125	Kansas City
Kaufman, Bruce A	190	St. Louis
Kaufman, Robert L	190	St. Louis
Kauk, Bruce A	050	N. Kansas City
Kaup, Chandra S	190	Florissant
Kayanan, Jose C	125	Kansas City
Kayes, Jack	190	St. Louis
Kays, Kenneth M	046	Osage Beach
Keairnes, Harold W	125	Kansas City
Keefe, David M	189	St. Charles
Keesal, Dennis	189	St. Charles
Kefalas, John C	074	Washington
Keitges, Pierre W	125	Overland Park, KS
Keller, Barbara P	026	Columbia
Keller, Maurice J	190	St. Louis
Keller, Robert M	189	St. Charles
Keller, Stephen M	190	St. Louis

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Kellett, John G	190	St. Louis
Kelley, Gilbert B	010	Savannah
Kelling, E. Collyer	082	Springfield
Kelly, Charles R	125	Kansas City
Kelly, James B	125	Kansas City
Kelly, John J	190	St. Louis
Kelly, John B	102	Joplin
Kelly, Joseph G	050	N. Kansas City
Keltner, Raymond O	125	Peculiar
Keltner, Raymond M, Jr.	190	St. Louis
Kemp, Michele E	190	Chesterfield
Kendall, Forrest H	125	Kansas City
Kendis, Joseph B	190	St. Louis
Kenneally, Cynthia Z	190	St. Louis
Kennedy, David G	190	St. Louis
Kennett, Jerry D	026	Columbia
Kenney, Douglas R	086	Clinton
Kenney, John D, III	125	Overland Park, KS
Kenney, John D	190	St. Louis
Kenney, Roy E	166	Neosho
Kensel, Robert S	082	Rogersville
Keohane, Mark	189	St. Charles
Kerkemeyer, George	150	Hannibal
Kerr, Harold H	125	Shalimar, FL
Kessel, James W	190	St. Louis
***Kesseler, Randall G**	082	Springfield
Kessler, William D, Jr.	102	Joplin
Kester, Carla G	082	Springfield
Kester, Nathan L	082	Springfield
Ketcherside, W. Joseph	050	N. Kansas City
Key, James S	082	Springfield
Khalil, Tamer G	082	Springfield
Khan, Abdul G	190	Arnold
Khan, Khalid I	042	Cape Girardeau
Khan, Khawla B	002	St. Louis
Khojasteh, Ali	026	Columbia
Khojasteh, Saaid	002	St. Louis
Khouri, Roger K	190	Key Biscayne, FL
Khoury, Cecile S	125	Leawood, KS
Khurana, Satish K	125	Lenexa, KS
Kiburz, Douglas W	178	Sedalia
Kichura, George M	190	St. Louis
Kiehl, Mary M	190	St. Louis
Kies, Richard L	042	Cape Girardeau
Kilgore, John W	190	St. Louis
Killen, Duncan A	125	Kansas City
Kim, Chul	034	Poplar Bluff
Kim, Stanley W	190	St. Louis
Kim, William W	190	St. Louis
Kim, Yang H	074	Washington
Kim, Yong Kie	042	Cape Girardeau
Kimble, Harvey S	125	Kansas City
Kimelman, Nathan	190	St. Louis
Kimlinger, William R	058	Jefferson City
Kimmey, James R	190	St. Louis
Kincaid, William L	190	St. Louis
Kinder, Doyle O	082	Springfield
Kinder, James A	042	Cape Girardeau
Kinder, Jerry L	042	Cape Girardeau
Kindred, Lynn H	125	Kansas City
King, Dana M, III	030	St. Joseph
King, Donald K	190	St. Louis
King, Eustace E, III	190	Chesterfield
King, Francis C	190	St. Louis
King, Frank K	170	Hayti
King, Gregory S	190	St. Louis
King, J. Tenbrook	125	Prairie Village, KS
King, James A	002	Des Peres
King, John V, Jr.	190	Ballwin
King, John V, Sr.	190	St. Louis
King, M. Kenton	190	St. Louis
King, Richard H	086	Clinton
Kingsbury, Robert J	189	St. Peters
Kingsland, Robert C	190	Sarasota, FL
Kinsella, Peter W	190	St. Louis
Kinsella, Ralph A, Jr.	190	St. Louis
Kipfer, Robert E	082	Springfield
Kipnis, David M	190	St. Louis
***Kirila, Carol E**	030	St. Joseph
Kirkland, Jerry A	050	Kansas City
Kirsch, Jeffrey P	190	St. Louis
Kissane, John M	190	St. Louis
Kissell, Richard W	082	Springfield
Kister, George E	189	Maryland Heights
Kistler, W. David, Jr.	190	St. Louis
Kitchens, Daniel L	215	St. Louis
Kitchin, Winston H	190	St. Louis
Kiyanclar, M. Emin	190	St. Louis
Klachko, David M	026	Columbia
Klearman, Micki	190	St. Louis
Klein, Kendel L	166	Mount Vernon
Klein, Saul J	190	St. Louis
Kleinschmidt, Donn C	190	St. Louis
Kleopfer, Lynn L	026	Columbia
Kletzker, George R	190	St. Louis
Kline, Carlyn M	030	St. Joseph
Kline, Edmund W	030	St. Joseph
Kline, James	030	St. Joseph
Klinkerfuss, George H	082	Springfield
Klippel, Allen P	190	St. Louis
Knabb, Henry F, Jr	082	Springfield
Knabb, Kenneth E	082	Springfield
Knakal, Roger C	002	Kansas City
Knapp, Jane F	125	Kansas City
Knight, James W	190	St. Louis
Knight, William A, Jr.	190	St. Louis
Knipschild, Bedford F	198	Marshall
Knoch, H. Kermit	125	Shawnee Mission, KS
Knock, Henry L	190	St. Louis
Knopf, Harry L	190	St. Louis
Knowles, R. Raymond	190	St. Louis
Knowlton, Norman P, III	082	Springfield
Knudson, Dennis R	026	Columbia
Kobbermann, Kobby J	082	Springfield
Koch, F. Daniel	125	Kansas City
Kodner, Ira J	190	St. Louis
Koehler, George A	190	St. Louis
Koenig, Marvin I	190	St. Louis
Koerner, Kenneth A	190	St. Louis
Kofkoff, Richard L	190	Bridgeton
Koh, David W	215	St. Louis
Kohler, Roy	082	Springfield
Kohm, Mary Jane F	002	St. Louis
Koivunen, Debra G	026	Columbia
Kolb, Lisa G	058	Jefferson City
Kolda, Michael A	042	Cape Girardeau
Kolker, Allan E	190	St. Louis
Kolze, Vernon W	082	Springfield
Koo, Michele D	190	St. Louis
Koon, Ben H	066	Bolivar
Koonce, John P	058	Jefferson City
Koontz, Kenneth L	125	Kansas City
Koontz, Paul G	125	Kansas City
Kopelson, Jeffrey C	190	Brewester, NY
Kopp, Kenneth R	125	Lenexa, KS
Kopp, Shelby K	190	St. Louis
Koppers, Lawrence E	082	Springfield
Korenblat, Phillip E	190	St. Louis
Korenfeld, Michael S	074	Washington
Korn, Dale E	215	Columbia
Korn, Robert L	190	St. Louis
Kosse, Karl E	030	St. Joseph
Kotner, Lawrence M, Jr.	190	St. Louis
Kouchoukos, Nicholas T	190	St. Louis
Kouo, Louis	042	Cape Girardeau
Kowert, Edward H	190	St. Louis
Kozminski, Mike	030	St. Joseph
Krabak, Michael J	215	St. Louis

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Kraeger, Russell R	190	St. Louis
Kraemer, Bruce A	190	St. Louis
Kraemer, Edwin T	125	Lee's Summit
Kraft, Jacob	125	Palm Springs, CA
Krahn, Eve M	050	Kansas City
Krahn, Henry C	082	Springfield
Krahn, Michael J	050	Kansas City
Krain, Samuel	190	St. Louis
Krajcovic, David P	190	Chesterfield
Kramer, Jeffrey B	125	Prairie Village, KS
Kramer, Robert S	190	St. Louis
Kraner, Justin F	190	St. Louis
Kranson, Seymour J	125	Guilford, CT
Kratz, Donald P	082	Springfield
Kraus, Frederick T	190	St. Louis
Krautmann, John J	058	Jefferson City
Krebs, Festus J, III	125	Kansas City
Krechel, Susan W	026	Jonesburg
Kretchmar, Alan P	190	St. Louis
Krettek, John E	190	Chesterfield
Kreusser, Katherine L	190	St. Louis
Krewet, Frank A, III	190	St. Louis
Kriegshauser, James W	190	St. Louis
Kriegshauser, Lawrence A	190	St. Louis
Krishna, Padma	125	Kansas City
Kroeger, George B, Jr.	190	St. Louis
Kroetz, Frank W	202	Sikeston
Krojanker, David N	190	St. Louis
Krojanker, Rolf J	190	St. Louis
Kromer, Charles J	190	St. Louis
Kronemer, Keith A	215	New Orleans, LA
Kronemer, Norton S	190	St. Louis
Krug, Paul E	125	Kansas City
Krummenacher, Thomas K	190	St. Louis
Kruse, Carl R	150	Palmyra
Kuangparichat, Manoch	118	Excelsior Springs
Kuckelman, Richard G	125	Kansas City
Kuebel, Richard J	190	St. Louis
Kuenzi, Donald E	050	Kansas City
Kuganeswaran, Eliathamby	215	Kansas City
Kuhlman, Ralph F	190	St. Louis
Kuhn, Lawrence F	190	Bridgeton
Kulak, Gary	190	St. Louis
Kulick, Eric M	125	Prairie Village, KS
Kulkarni, Nandini S	190	St. Louis
Kumari, Vijaya	190	St. Louis
Kunda, Koteswara R	190	St. Louis
Kunst, Edward J	190	Ballwin
Kunz, Stephen R	125	Overland Park, KS
Kurtz, Karl J	125	Kansas City
Kussman, Mary E	002	St. Louis
Kuvshinoff, Boris W	026	Columbia
Kyger, John E	125	Independence

L

Laatsch, Robert H	034	Poplar Bluff
LaBach, James P	125	Overland Park, KS
Labayen, Ricardo A	125	Overland Park, KS
Lacey, Hugh L	102	Joplin
LacKamp, Robert J	030	St. Joseph
Ladd, Charles B	190	St. Louis
Ladd, Christine M	190	St. Louis
LaDriere, Raymond J	190	St. Louis
LaFerriere, Keith A	082	Springfield
LaFoe, William K	042	Cape Girardeau
LaFrancis, Irving E	102	Joplin
LaHue, William C	118	Lexington
Laiben, Gregg R	125	Kansas City
Laird, John M	190	St. Louis
Lakusiewicz, Ronald J	034	Poplar Bluff
Lally, James J	125	Kansas City
Lamb, Jerome P	125	Blue Springs
Lamb, Wanda	190	St. Louis
Lambie, Rodger W	125	Kansas City
Lammoglia, Francisco J	030	St. Joseph
LaMonda, Gary W	026	Columbia
Lamonte-Jost, Daniel J	026	Columbia
Lampert, Benjamin A	082	Springfield
Lamping, J. Daniels	190	St. Louis
Lampros, William P	190	St. Louis
Lampton, Lawrence M	026	Columbia
Landau, David W	190	St. Louis
Landau, William M	190	St. Louis
Landers, Burnell	125	Independence
***Landers, Gary A**	050	N. Kansas City
Landgraf, James R	125	Independence
Landhuis, Leo R	026	Rochester, NY
Landis, George K	125	Raymore
Landman, Danielle	002	St. Louis
Landrum, Alice L	026	Columbia
Landsbaum, Charles J	058	Jefferson City
Lane, Daniel K	190	St. Louis
Lang, John J	190	St. Louis
Lange, David R	190	Bridgeton
Langley, Harriet S	125	Kansas City
Lankachandra, Bharata	010	Savannah
Lankford, Harold D	014	Mexico
Lapi, Angelo	125	Boca Raton, FL
LaPietra, Martha M	125	Kansas City
Laposky, Lynda L	190	Chesterfield
Larsen, William E	125	Shawnee Mission, KS
Larson, Kenneth W	082	Springfield
Laster, Jerry L	102	Joplin
Laster, Steven B	125	Kansas City
Latham, Raymond W	125	Mission Hills, KS
Latif, Azhar	118	Lexington
Latimer, Walter N	050	Gladstone
Latour, Jonathan G	026	Columbia
Lattinville, Henry E	190	Bridgeton
Lauber, Joseph J	190	St. Louis
Lauer, Danl J	125	Overland Park, KS
Lauer, John D	190	St. Louis
Laughlin, Edward J	125	Independence
Laughlin, Thomas P	125	Kansas City
Laux, France A	190	Tucson, AZ
Lavery, Daniel P	058	Westphalia
***Law, Byron D**	050	Kansas City
Lawrence, Willie E, Jr.	125	Overland Park, KS
***Lawson, Gina E**	002	Smithville
Lawson, Noel W	026	Columbia
Lawton, John T	190	St. Louis
Leary, Daniel J	190	St. Louis
LeBlanc, Leo J	190	Clayton
Lederer, Charles M, Jr.	125	Kansas City
Lederer, Chas M, Sr	110	Warrensburg
Lee, David Y S	042	Cape Girardeau
Lee, Fransiska A	190	St. Louis
Lee, Gerald B	214	Kansas City
Lee, H. T.	026	Columbia
Lee, Henry A	125	Snowmass Village, CO
Lee, Jung H	106	Crystal City
Lee, King Y	125	Shawnee Mission, KS
Lee, Leander K	190	St. Louis
Lee, Susan L	125	Kansas City
Lee, Tae H	125	Leawood, KS
Lee, Thomas K	190	St. Louis
Lee, Wilfred	042	Cape Girardeau
Leech, Maurice P	026	Fayette
Leeper, Sidlee W	026	Rocheport
LeFevre, Philip J	082	Springfield
Legarda, Maria M	125	Kansas City
Legler, Larry E	125	Independence
Lehman, John J, Jr.	215	St. Louis
Lehman, Richard C	190	St. Louis
Lehman, Robert B	190	St. Louis
Leibsohn, Joel M	125	Independence
Leidenfrost, Ronald D	190	Chesterfield
Leifer, William W	125	Kansas City

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Leightner, William F	190	St. Louis
Leitch, Steven M	082	Springfield
Leming, Bert H	190	St. Louis
Lenobel, Milton I	190	Longboat Key, FL
Lents, Rickey L	042	Cape Girardeau
Lentz, Harold C	166	Neosho
Lentz, Harold C, Jr.	125	Independence
Lentz, Kathy J	074	Washington
***Lentz, Rodney D**	058	Jefferson City
Lenzenhuber, Karl J	074	Washington
Leonhardt, Erwin M	190	St. Louis
Lepkowski, Hemlata K	026	Columbia
Lerner, Bruce	125	Independence
Lerner, Scott A	125	Kansas City
Leroux, Gene H	034	Doniphan
Lerwick, Everett R	190	St. Louis
Leslie, James T	058	Jefferson City
Letizia, Wayne L	125	Independence
Levenson, Ernest	034	Poplar Bluff
Levenson, Ina	034	Poplar Bluff
Levi, Bernard	125	Overland Park, KS
Levine, Laurence A	190	St. Charles
Levine, Richard S	190	St. Louis
Levitt, Joseph	190	St. Louis
Levitt, Robert G	190	St. Louis
Levy, Edward S	002	St. Louis
Levy, Jerome F	190	St. Louis
Levy, Morton A	190	St. Louis
Lewandowski, Molly J	125	Leawood, KS
Lewin, W. Howard	190	St. Louis
Lewis, J. Eugene	190	St. Louis
Lewis, Lawrence M	190	St. Louis
Lewis, Matthew T	058	Jefferson City
Lewis, Noel R	082	Springfield
Lewis, Revis C	125	Kansas City
Lewis, Robert D	190	St. Louis
Lewis, William S	042	Cape Girardeau
Liang, Jing C	125	Independence
Libel, Roy D	082	Springfield
Librach, Stanley L	215	Westwood Hills, KS
Lichtor, Jos M	125	Mission Hills, KS
Lichty, Chas A	150	Shelbina
Lieb, Francis X	190	St. Louis
Lieb, Thomas F	190	St. Louis
Lieberman, David M	190	St. Louis
Lierz, Mark F	030	St. Joseph
***Light, Diane L**	058	Jefferson City
Lila, Aram	050	Excelsior Springs
***Lillig, James F**	050	Kansas City
Lilly, Douglas R	190	St. Louis
Lima, Jose A	190	St. Louis
Limpiphiphatn, Dhajphong	174	Perryville
Limpiphiphatn, Ester P	174	Perryville
Lin, C H	046	Moberly
Lin, Chi-Hsi	082	Springfield
Lin, H T	046	Moberly
Lin, Hsiu-San	190	St. Louis
Linde, John W	135	Rolla
Lindeman, John F	190	Chesterfield
Lindgren, Carleton J	125	Independence
Link, Alexander J	190	St. Louis
Link, Vance E	125	Independence
Linsenmeyer, Charles M	189	St. Charles
Lintecum, Frederick B	125	Kansas City
Linville, Howard E	125	Leawood, KS
Lipschitz, Ervin	190	St. Louis
Lipsitz, Ellis S	190	Chesterfield
Lisbon, Eleanor A	125	Kansas City
Lischwe, Daniel H	190	Bridgeton
Liss, Jay L	190	St. Louis
Little, Blake A	102	Joplin
Littlejohn, Robert T	050	N. Kansas City
Litton, Lyle D	082	Boca Raton, FL
Litton, Lynn O	026	Boca Raton, FL
Litzow, Peter L	190	St. Louis
Liu, Ben C	125	Kansas City
Liu, Kenneth A	215	St. Louis
Llorens, Alfred S	026	Columbia
Lobati, Frederick	215	Kansas City
Lobdell, Creig M	082	Springfield
Lockard, Orlyn O	030	St. Joseph
Lockwood, Gary F	125	Kansas City
Loeb, Mark	026	Columbia
Loeb, Richard H	082	Springfield
Loeb, Virgil, Jr.	190	St. Louis
Loeffler, Roberta L	190	St. Louis
Loeppky, Carol B	026	Columbia
Lofgreen, Craig S	002	Kansas City
Loftus, Loretta S	125	Kansas City
Loggan, Michael B	050	Liberty
Logie, Macdonald B	190	St. Louis
***Logston, David G**	082	Springfield
Logue, John T	026	Columbia
Lohmar, Roland E	026	Columbia
Lohr, Robert W	190	St. Louis
Lohrentz, Lois H	125	Shawnee Mission, KS
Loitman, Bernard S	190	St. Louis
Lomax, John E	208	Branson
Lombardo, Joseph A	190	St. Louis
Londe, Alan M	190	St. Louis
Londe, Sol	190	Northridge, CA
London, Stanley L	190	St. Louis
Lonergan, James H	125	Kansas City
Lonergan, Warren M	190	Chesterfield
Long, Curtis W	214	Butler
Long, Edwin T	125	Kansas City
Long, John W	026	Columbia
Long, Priscilla E	150	Hannibal
Long, R. Stacy	125	Lake Lotawana
Long, Stephen E	082	Springfield
Long, Timothy P	074	Marthasville
Long, W. Steven	030	St. Joseph
Lonsway, Maurice J, Jr.	190	St. Louis
Loomis, James F	190	St. Louis
Looney, Steven C	030	St. Joseph
Lopez-Plata, Roberto	125	Leawood, KS
Lord, Richard E	190	St. Louis
Lorei, John M	002	Kansas City
Loren, Michael L	125	Independence
Lorenc, Ernest	082	Springfield
Lorenzo, Edilberto B	034	Poplar Bluff
Lottes, J. Otto	190	St. Louis
Loughead, John R	034	Poplar Bluff
Loutzenhiser, James K	125	Kansas City
Love, Gerry A	125	Liberty
***Lovern, Royce E**	074	Washington
Lovinger, Warren C, Jr.	214	Nevada
Lovinggood, J. Perry	190	Bridgeton
Lovinggood, Thomas A	042	Cape Girardeau
Lowe, H. Arch, Jr	082	Springfield
Lowell, Jeffrey A	190	St. Louis
Loyd, Earl L	058	Holts Summit
Loynd, Robert C	190	St. Louis
Lubniewski, Anthony J	190	St. Louis
Luby, Maureen T	215	St. Louis
Lucas, Thomas G	190	St. Louis
***Lucio, John C**	058	Jefferson City
Luckenbill, Paul T	054	Park Rapids, MN
Luckett, Marc A	215	Kansas City
Ludwig, Mark A	190	St. Louis
Ludwikosky, Mikel A	125	Lee's Summit
Luechtefeld, Frank	190	Florissant
Lueckenhoff, Rebecca R	058	Jefferson City
Luerding, Jeffrey A	050	Kansas City
Luetje, Charles M	125	Kansas City
Luetkemeyer, Dennis C	215	Columbia
Luetkemeyer, James G	058	Jefferson City
Lugo, Saml	190	St. Louis

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Luh, Andrew M	190	St. Louis
Lukavsky, James P	208	Branson
Lund, Herluf G	190	St. Louis
Lund, Herluf G, Jr.	190	Chesterfield
Lundman, Hugh	082	Springfield
Lurie, H H	082	Springfield
Lusk, Charles A	214	Butler
Luther, George A	190	St. Louis
Lutkewitte, Joseph F	174	Ste. Genevieve
Lux, Gregory K	082	Springfield
Luzecky, Michael H	082	Springfield
Lyle, Robt R	120	Versailles
Lyles, Rodney	125	Overland Park, KS
Lyman, Edward H	190	St. Louis
Lynch, Thomas W	082	Springfield
Lyon, David B	125	Prairie Village, KS
Lyons, Daniel F	082	Springfield
Lyskowski, John C	058	Jefferson City
Lyskowski, Maria M	058	Jefferson City
Lyss, Carl A	190	St. Louis
Lytle, Edwin L	190	St. Louis
Lytle, Michael F	125	Shawnee Mission, KS

M

Maben, Sam E	125	Kansas City
Macdonnell, Thomas M	210	Marshfield
Machek, Otakar	190	St. Louis
Mack, Marvin L	026	Columbia
Macleod, Angus	190	St. Louis
Macler, Henry H, Jr.	190	Augusta
MacDonald, Robert R, Jr.	190	St. Louis
MacDonald, Robert R, III	215	St. Louis
MacDonald, Robin R	125	Kansas City
MacDonald, William C	190	St. Louis
MacGee, Edwin E	125	Kansas City
MacGorman, Linda R	082	Springfield
MacKinnon, Susan E	190	St. Louis
MacLaughlin, James C	102	Hot Springs, AR
MacNaughton, Ralph E	125	Kansas City
MacNaughton, Robert A, II	050	Liberty
MacNaughton, Robert A	125	Kansas City
Madden, Michael L	125	Kansas City
Maddipati, Sreedevi	190	St. Louis
Madduri, Aruna D	034	Poplar Bluff
Madduri, Sivaprasad D	034	Poplar Bluff
Madrid, Dominador O	190	St. Louis
Magaletta, George E	002	St. Louis
Magaw, David C	066	Everton
Magee, Robert L	214	Eldorado Springs
Magee, W. Edwin	190	Imperial
***Magill, William S**	082	Springfield
Maginn, Richard L	030	St. Joseph
Magruder, Lyell M	214	Nevada
Mahboubi, Aziz O	202	Scottsdale, AZ
Maher, Robert W	082	Springfield
Mahmoud, Said F	125	Kansas City
Mahnken, Robert F	082	Springfield
Mais, Thomas E	125	Shawnee Mission, KS
Maitz, Carlos A	190	St. Ann
Major, Troy E	082	Springfield
Majors, Patrick F	190	St. Louis
Majzoub, Hish S	102	Joplin
Makos, Mignon M	030	St. Joseph
Mallouk, Alexander G	125	Kansas City
Mallow, James E	125	Kansas City
Malmberg, Virgil L	190	Chesterfield
Maminta-Streiff, Maria G	190	St. Louis
Manansala, Antonio Q	190	St. Louis
Mangalat, Narayanan K	102	Joplin
Mangum, William B	125	Independence
Mani, Mary E	190	Clayton
Manire, John E	102	Joplin
Mann, James K	150	Hannibal
Manning, Peter B	125	Kansas City
Mannis, Charles I	190	St. Louis
Manske, Paul R	190	St. Louis
Mantell, Jack M	082	Springfield
Mantovani, John F	190	St. Louis
Maple, Francis M	082	Springfield
Marbarger, John P, Jr.	190	St. Louis
Marchiando, Albert W	074	Washington
Marchosky, J. Alex	190	Chesterfield
Marcus, Michael D	190	St. Louis
Marcus, Morris D	190	St. Louis
Mardini, Edward E	138	Bonne Terre
Margolis, David M	190	St. Louis
Marietta, William G	042	Cape Girardeau
Markway, Gregory A	125	Independence
Marr, Garrett L	125	Kansas City
Marrs, David B	189	St. Charles
Marsh, Jeffrey L	190	St. Louis
Marshall, Hal E	125	Overland Park, KS
Marshall, Jay P, II	190	Chesterfield
Marshall, Michael P	002	Kansas City
Marshall, William G	026	Glasgow
Marshall, William H	058	Jefferson City
Marston, F. James	030	St. Joseph
Marti, Larry B	135	Rolla
Martin, Chris J	026	Columbia
Martin, Clarence A	102	Joplin
Martin, Daniel J, Jr.	190	St. Louis
Martin, Daniel J	190	St. Louis
Martin, David S	190	Chesterfield
Martin, Jeffrey W	190	St. Louis
Martin, Mark W	125	Lee's Summit
Martin, Richard A	042	Cape Girardeau
Martin, Robert A	206	West Plains
Martin, Scott A	190	Chesterfield
Martin, Stanley B	190	St. Charles
Marty, David R	058	Jefferson City
Martz, John C	190	St. Louis
Maslan, Mark J	125	Overland Park, KS
Mason, Mary Jane	135	Steelville
Mass, Joan H	190	St. Louis
Massey, Vickie	125	Kansas City
Masters, Edwin J	042	Cape Girardeau
Masters, William H	190	Tucson, AZ
Matava, Matthew	190	St. Louis
Mathew, Ruby	190	Chesterfield
Mathews, Jeffrey E	190	St. Louis
Matile, Gerald U	125	Kansas City
Matlock, Mark S	102	Joplin
Matovich, Violet B	125	Kansas City
Matson, Jeffrey A	125	Kansas City
Matta, Camille S	125	Kansas City
Mattax, James B, Jr.	082	Springfield
Matthews, J. Mark	125	Kansas City
Matthews, John I	058	Jefferson City
Matthews, John G	190	Prairie Village, KS
Matthews, Richard H	135	Rolla
Matthews, Thomas D	074	Washington
Maughs, Sydney B	190	St. Louis
Mauldin, Charles C	082	Springfield
Maupin, Kathy C	190	St. Louis
Maxson, Katherine A	190	Chesterfield
Maxson, Theodore R	110	Warrensburg
Mayer, John H, Jr.	125	Shawnee Mission, KS
Mayer, Lawrence M	042	Cape Girardeau
Mayer, Robert A	190	Pocono Pines, PA
Mayes, Ben R	190	St. Louis
Maylack, Fallon H	190	Florissant
Maynard, Colleen M	125	Kansas City
Mayuga, Edgardo G	190	St. Louis
Mayuga, Laureano G	206	Cabool
Mayus, Joseph L	082	Springfield
McAdam, C. Rush	190	St. Louis
McAfee, Gordon	082	Springfield
McAllister, John W, II	189	St. Peters

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*Doctor of Osteopathy

McArthur, Carole P	**215**	Kansas City
McBride, Marsha M	**215**	St. Louis
McCabe, Eugene J	**189**	St. Charles
McCadden, Michael E	**190**	St. Louis
McCalla, John P	**050**	Kansas City
McCallister, Ben D	**125**	Kansas City
McCanse, Andrew	**125**	Belton
McCanse, Lynn R	**050**	N. Kansas City
McCarthy, Christopher	**190**	St. Louis
McClain, Thomas D	**082**	Springfield
McCloud, Deborah J	**102**	Joplin
McClung, Mark W	**125**	Kansas City
McConahay, David R	**125**	Kansas City
McConchie, James E	**125**	Lee's Summit
McCool, James F	**190**	St. Louis
McCorcle, Marcus D	**082**	Springfield
McCord, E. Scott	**026**	Columbia
McCormack, Robert E	**125**	Kansas City
McCormick, James E	**050**	Kansas City
McCown, Allan H	**190**	St. Louis
McCoy, Frederick J	**125**	Shawnee Mission, KS
McCray, Glen M	**082**	Springfield
McCray, Stephen A	**050**	N. Kansas City
McCroskey, Brian L	**125**	Kansas City
McCroskey, Lon C	**125**	Kansas City
McCullough, Joseph E	**125**	Kansas City
McDavid, Robert E	**026**	Columbia
McDermott, Alfred E	**174**	Perryville
McDonald, Herbert L	**066**	Bolivar
McDonald, James H	**125**	Kansas City
McDonald, Margaret E	**102**	Joplin
McDonald, Michael G	**102**	Joplin
McDonald, Robert J	**058**	Jefferson City
McDonald, Wallace	**030**	St. Joseph
McDonnell, John F	**125**	Kansas City
McDonough, Michael	**002**	St. Louis
McDowell, James W	**014**	Mexico
McElroy, George L, III	**058**	Jefferson City
McElroy, Glenn L	**026**	Columbia
McEnroe, John D, Jr.	**125**	Kansas City
McFadden, Gene A	**118**	Waverly
McFarland, H. R.	**125**	Shawnee Mission, KS
McFarland, Rodney J	**166**	Neosho
McGahee, C. Leon	**190**	St. Louis
McGinnis, William F	**190**	Chesterfield
McGinty, Charles P	**042**	Cape Girardeau
McGinty, Frank H	**042**	Cape Girardeau
McGonigle, James P	**102**	Joplin
McGonigle, Michael M	**102**	Joplin
McGovney, Janice K	**050**	Kansas City
McGraw, James P	**215**	Kansas City
McGuire, Patricia A	**190**	St. Louis
McGuire, Thomas H	**125**	Overland Park, KS
McIntire, Timothy L	**058**	Jefferson City
McIntosh, Donald E	**125**	Kansas City
McIntosh, Douglas A	**042**	Cape Girardeau
McIntosh, Michele C	**125**	Independence
McKay, Mark T	**215**	Kansas City
McKeel, Thomas B	**125**	Kansas City
McKenzie, Randolph A	**125**	Kansas City
McKeown, Robert A	**206**	Bucyrus
McKinney, Daniel C	**082**	Springfield
McKinney, John W	**190**	St. Louis
McKinsey, David S	**125**	Kansas City
McKnight, Scott J	**050**	Liberty
McLaren, David L	**026**	Columbia
McLaughlin, Richard D	**082**	Springfield
McLaughlin, Sean T	**215**	Kansas City
McLemore, Willie O	**125**	Kansas City
McManus, Gerald	**050**	N. Kansas City
McMeekin, Sheila P	**125**	Shawnee Mission, KS
McMillan, David L	**166**	Neosho
McMillen, James J	**030**	St. Joseph
McMillin, John N	**082**	Springfield
McMorrow, Nora K	**190**	Crestwood
McMullin, Forbes A	**190**	St. Louis
McMurray, Scott W	**082**	Springfield
McMurry, Ted A	**082**	Springfield
***McNabb, M. Jeffery**	**042**	Cape Girardeau
McNamara, John J	**190**	St. Louis
McNeal, Douglas M	**082**	Springfield
McNitt, Jay D	**125**	Kansas City
McPhee, Mark S	**125**	Kansas City
McQue, Ellen L	**150**	Hannibal
McQueary, Frederick G	**082**	Springfield
Meadows, C. Douglas	**190**	St. Louis
Medler, John F	**190**	St. Louis
Medler, P. Louis	**190**	St. Louis
Medlicott, William J	**125**	Port Townsend, WA
Mehaffy, Orville A	**102**	Joplin
Mehlhorn, Gary L	**082**	Springfield
Mehr, David R	**026**	Columbia
Mehra, Ravi	**190**	St. Louis
Meidl, Erik J	**150**	Hannibal
Meier, Francis X	**058**	Jefferson City
Meier, Mitchell S	**102**	Joplin
Meinberg, William H	**190**	North Ridge, CA
Meiners, Theodore M	**190**	Chesterfield
Mejia, Victor E	**202**	Sikeston
***Melchior, David E**	**174**	Perryville
Meldi, Dominic M	**082**	Springfield
Melgaard, Sven R	**125**	Leawood, KS
Melia, B J, Jr.	**125**	Kansas City
Mell, Roger L	**190**	Chesterfield
***Mellies, Steven D**	**042**	Cape Girardeau
Meltz, Gary J	**189**	St. Charles
Memken, John A	**150**	Hannibal
Menchetti, Donald E	**082**	Springfield
Mendelsohn, George E	**190**	Chesterfield
Mendelsohn, Robert S	**190**	St. Louis
Mendez, Maria A	**082**	Springfield
Mendonsa, Lawrence E	**190**	Chesterfield
Menne, Marvin C	**138**	Ironton
Mentgen, Carl N	**082**	Springfield
Merenda, Frank J	**190**	St. Louis
Merenda, James T	**190**	St. Louis
Merenda, Sam J	**190**	St. Louis
Meridy, Howard W	**102**	Joplin
Merkel, Kurt D	**190**	St. Louis
Merkle, John A	**190**	St. Louis
Merritt, Burch A	**190**	St. Louis
Mertz, Janet S	**125**	Kansas City
Messmore, Virginia P	**215**	Kansas City
Mestad, Peter H	**125**	Kansas City
Mestres, Hugh M	**190**	St. Louis
Metry, Donald J, Jr.	**078**	Chillicothe
Metzler, Michael H	**026**	Columbia
Meyer, D. Joseph, Jr.	**026**	Columbia
Meyer, Jay L	**190**	St. Louis
Meyer, Jerry L	**118**	Concordia
Meyer, John W	**082**	Springfield
Meyer, John S	**190**	Chesterfield
Meyer, Paul W	**125**	Shawnee Mission, KS
Meyer, Randall E	**058**	Jefferson City
Meyer, Robert C	**190**	St. Louis
Meyers, Elsie F	**190**	St. Louis
Meyers, Jerry R	**189**	St. Peters
Meyers, John B	**190**	St. Louis
Meyers, Robert W	**190**	St. Louis
Meystrik, Rosellen S	**082**	Springfield
***Michael, Roy A**	**058**	Jefferson City
Michael, Vernon E	**190**	St. Louis
Michaels, Robert H	**082**	Springfield
Michelson, Richard B	**125**	Kansas City
Middleton, Jerry N	**190**	Chesterfield
Middleton, Mary Jo	**030**	St. Joseph
Miedema, Brent W	**026**	Columbia
Mihalevich, John A, Jr	**082**	Springfield

*Doctor of Osteopathy

Milder, Barry D	190	St. Louis
Milder, Benj	190	St. Louis
Miles, George O	125	Shawnee Mission, KS
Miles, John D	215	Columbia
Miles, Richard W	102	Joplin
Miles, Wayne B	082	Springfield
Milgram, Byron A	125	Kansas City
Mill, William B, Jr.	190	St. Louis
Miller, Charles, Jr.	190	St. Louis
Miller, Charles W	190	St. Louis
Miller, Dace L	082	Springfield
Miller, Donald	058	Jefferson City
Miller, Geoffrey W	190	St. Louis
Miller, Gerald L, Jr.	125	Kansas City
Miller, Harry G	086	Clinton
Miller, James E	190	St. Louis
Miller, John T	125	N. Kansas City
Miller, Joseph P	042	Cape Girardeau
Miller, Jule P	190	St. Louis
Miller, Leroy J	026	Columbia
Miller, Pamela S	135	Rolla
Miller, Robert N	190	St. Louis
Miller, Suzanne L	190	Grover
Miller, William D	030	St. Joseph
Miller, Wilson H	125	Shawnee Mission, KS
Millet, Ruth E	125	Kansas City
Mills, Melissa J	002	Overland Park, KS
Millwee, Elizabeth M	026	Centralia
Milne, Jay L	082	Springfield
Minkoff, I. Monica	189	St. Peters
Minnigerode, Lana K	125	Kansas City
Minnigerode, Turner L	125	Kansas City
Mir, A. Rauf	125	Kansas City
Mirbaha, Mitchell M	190	St. Louis
Mischnick, Carol R	190	Chesterfield
Miskovsky, Emil F	190	St. Louis
Missey, Wilburn C	190	Chesterfield
Mistry, Tehmton S	190	Columbia, IL
Mitchell, Andrew D	125	Prairie Village, KS
Mitchell, Franklin L	026	Columbia
Mitchell, Jason	215	Columbia
Mitchell, John D	125	Kansas City
Mitchell, Lynn D	026	Columbia
***Mitchell, Richard N**	042	Cape Girardeau
***Mitchem, Randall E**	058	Jefferson City
Mitra, Nirmal K	125	Kansas City
Mitterando, James L	215	Kansas City
Mizell, Myron W	082	Springfield
Mobley, Gilbert L	082	Springfield
Moeller, F. Delbert	189	Lake St. Louis
Moffe, Thomas C	082	Springfield
Mohs, Frank R	190	St. Louis
Mohsen, Aly M	082	Springfield
Molberg, Peter J	082	Springfield
Molden, C. Scott	190	St. Louis
Molden, Charles A	190	Ballwin
Mollman, H. Dennis	190	Chesterfield
Monaco, Michael	125	Harrisonville
Monafo, William W	190	St. Louis
Monaghan, Greg G	026	Columbia
Monroe, C. Dean	026	Columbia
Monteleone, Patricia L	190	St. Louis
Montello, Samuel A	125	Shawnee Mission, KS
Monterubio, Fred R, Jr.	190	St. Louis
Montes, Arturo C	190	Florissant
Montgomery, Austin F	190	St. Louis
Montgomery, Michael A	125	N. Kansas City
Montie, Joseph E	026	Columbia
Montoya-Vinluan, Aurea C	125	Raytown
Moody, Brent R	215	St. Louis
Mooney-Smith, Patricia	125	Kansas City
Moore, Candice A	215	Topeka, KS
Moore, Harry G, Jr.	190	St. Louis
Moore, John M	125	Kansas City
Moore, Michael R	206	West Plains
Moore, Michael T	214	Nevada
Moore, Richard E	042	Cape Girardeau
Moore, Thomas B	102	Joplin
Moore, Walter L	190	St. Charles
Moran, Thomas M	190	St. Louis
Morantz, Robert A	125	Kansas City
Moranville, Benedict A	030	St. Joseph
Morehead, William E	070	Malden
Morehouse, Paul D	074	Washington
Moreton, David W	026	Columbia
Morey, Kirk P	190	St. Louis
Morgan, David B	125	Kansas City
Morgan, Dix R	042	Cape Girardeau
Morgan, Edward B	190	St. Louis
Morgan, Harry C	190	Waynesville
Morgan, John L	082	Springfield
Morgan, Mary	002	St. Louis
Morgan, Stephan S	190	St. Louis
Morgan, Vincent I	054	Cameron
Morgan, W. Tom, Jr.	026	Columbia
Morgan, Willy J C	190	E. St. Louis, IL
Moriconi, William J	190	St. Louis
Moritz, Gerald	190	Bridgeton
Moritz, K. Lynne	190	St. Louis
Morley, Mary A	190	Chesterfield
***Morley, Ronald F**	058	Jefferson City
Morris, Alan H	190	St. Louis
Morris, J H	125	Independence
Morris, John J	026	Columbia
Morris, R. William	190	St. Louis
Morris, Terry V	125	Independence
Morrison, Arlen E	190	St. Louis
Morrison, R. Gideon	178	West Plains
Morrison, Richard A	125	Independence
Morrison, Stephen K	082	Springfield
Morrison, Thomas A	166	Aurora
Morrison, Tom V	208	Branson
Morrow, N. Eugene	082	Springfield
Morse, John P	070	Kennett
Morton, David J	190	St. Louis
Morton, Paul C	082	Springfield
Morton, Wayne L	214	Osceola
Mosby, Larry D	026	Columbia
Moseley, F. Thomas	082	Springfield
Moses, Robert A	190	St. Louis
Mosher, Amy A	002	St. Louis
Mosley, Julian C	190	St. Louis
Moss, Paul	125	Overland Park, KS
Mossie, Raymond D	050	Kansas City
Motchan, Dennis G	190	Bridgeton
Motier, Thomas H	190	St. Louis
Mou, Susan M	125	Kansas City
Mowrey, William O	190	St. Louis
Muckerman, Richard C, II	190	St. Louis
Muckerman, Richard I.C.	190	St. Louis
Muegge, F. David	082	Springfield
Mueller, Adolph R	102	Joplin
Mueller, Clarence E	190	O'Fallon
Mueller, Joseph A	190	St. Louis
Mueller, Martin J	125	Kansas City
Mueller, Randall E	026	Columbia
Muhammud, Faquir	190	St. Louis
Muhm, H. Yale	189	St. Charles
Mujica, Patricio H	030	St. Joseph
Mukharji, Jhulan	125	Kansas City
Mulder, George D	030	St. Joseph
Mullarky, Wilbur A	190	Oviedo, FL
Mullen, Jack	138	Bonne Terre
Mullen, Mary E	014	Mexico
Mullican, Charles N	030	St. Joseph
Mullins, Bernard L	050	Kansas City
Mullins, John E	190	Chesterfield
Mundy, David C	125	Kansas City

*Doctor of Osteopathy

Mundy, William L	125	Merriam, KS
Munger, Michael L	125	Kansas City
Munro, John S	125	Kansas City
Muraywid, Ahmad H	014	Mexico
Murdock, Nathaniel	190	St. Louis
Murphy, J. Peter, Jr.	190	St. Louis
Murphy, James A	030	St. Joseph
Murphy, John P	125	Overland Park, KS
Murphy, Margaret A	215	St. Louis
Murphy, Michael C	190	St. Louis
Murphy, Timothy P	030	St. Joseph
Murrell, H. Jerry	026	Columbia
Muscato, Joseph J	026	Columbia
Muscato, Mary S	026	Columbia
Musick, William D	026	Jefferson City
Mutchnick, Norman	125	Kansas City
Myears, Donald W	082	Springfield
Myers, Carl M	125	Platte City
Myers, Duane E	102	Joplin
Myers, Gary H	190	Chesterfield
Myers, George H	125	Kansas City
Myers, John S	125	Kansas City

N

Nachtigal, Michael P	082	Springfield
Nadolski, Gary S	030	St. Joseph
Nagle, Michael G	102	Joplin
Nagy, Al L	034	Doniphan
Nagy, Rickey E	125	Kansas City
Nair, Jyotsna	215	Columbia
Nanson, Duane	026	Columbia
Narayan, Dilip L	190	Chesterfield
Narkiewicz, Lawrence S	190	St. Louis
Nash, Alison C	190	St. Louis
Nash, Helen E	190	St. Louis
Nash, Homer E, Jr.	190	St. Louis
Nathan, Lester J	190	Fenton
Near, David M	190	Florissant
Neblett, Lewis M	082	Rogersville
Neely, J. Gail	190	St. Louis
Neighbor, Ernest H	125	Kansas City
Neihart, Robert E	125	Kansas City
Nelson, Bentley A	125	Leawood, KS
Nelson, David E	082	Springfield
Nelson, Donald C	082	Springfield
Nelson, J. Roger	190	St. Louis
Nelson, Michael J	125	Lee's Summit
Nelson, Paul W	125	Kansas City
Nelson, Richard E	125	Kansas City
Nemec, Edward S	190	St. Louis
Nepute, James A	190	St. Louis
Nesselrode, John H	125	Independence
Neu, Kenneth W	082	Springfield
Neu, Leo T, Jr	082	Springfield
Neu, Leo T, III	082	Springfield
Neu, Stephen J	082	Springfield
Neuman, Neal	190	St. Louis
Newman, Joseph A	102	Joplin
Newman, Mary J	166	Cassville
Newman, Matthew	190	St. Louis
Newman, Robert L	125	Kansas City
Newman, William R	102	Joplin
Newman-Koehn, Mica K	198	Marshall
Newport, Gerald	190	Florissant
Newport, Mark D	082	Springfield
Nguyen, Helen T	030	St. Joseph
Nguyen, Khanh X	002	Kansas City, KS
Nicholas, Stephen P	190	St. Louis
Nicholis, G. Ronald	125	Kansas City
Nichols, Margaret E	102	Joplin
Nichols, W. Kirt	026	Columbia
Nickell, Margaret B	125	Kansas City
Nickell, Michael D	102	Joplin
Nicolai, Charles H	190	St. Louis
Niedermeyer, George J	190	St. Louis
Nielsen, Carl H	190	St. Louis
Niemeyer, John H	190	St. Louis
Niesen, Anna R	190	St. Louis
Niesen, Frank J	190	St. Louis
Niesen, Thomas E	190	Chesterfield
Nieuwenhuizen, Maarten	026	Columbia
Nigh, Stephen S	125	Kansas City
Nigro, Thomas L	125	Kansas City
Nile, David A	190	St. Louis
Nishi, Toshio	190	St. Louis
Nitta, Diane M	082	Springfield
Nix, J. Gustavo	066	Bolivar
Nixon, Edward E	078	Independence
Noback, Richardson K	125	Las Vegas, NV
Nogalski, Michael P	190	St. Louis
Noh, Kyung M	026	Columbia
Nolan, Charles J	190	Chesterfield
Nolker, Stephen G	215	Kansas City
Noltensmeyer, Milton H	125	Lenexa, KS
Nomura, Roy M	190	St. Louis
Nordhues, Craig A	082	Springfield
Nordlicht, Scott M	190	St. Louis
Norland, Charles C	190	St. Louis
Nottmeier, Eric W	215	Columbia
Novack, Mark A	190	Chesterfield
Nowotny, Thomas J	190	St. Louis
Nuetzel, John A	190	St. Louis
Nulton, Carnie C	125	Kansas City
Nwaobasi, Sam	190	Florissant
Nyazee, Muhammad A	190	Bridgeton
Nye, Terry R	082	Springfield

O

Oakley, Margaret M	190	St. Louis
O'Brien, Edward J, Jr.	190	St. Louis
O'Brien, Robert M	190	St. Louis
Oeceno, Victor G	166	Cassville
Ochoa, Pedro	190	Valmeyer, IL
Ockner, Samuel A	190	Chesterfield
O'Connell, Timothy	190	St. Louis
O'Connor, John J	074	St. Louis
O'Connor, Mary C	125	Kansas City
O'Connor, Robert J	190	Florissant
O'Donnell, Francis E	190	St. Louis
O'Donnell, Susan M	174	Ste. Genevieve
O'Farrell, Thomas P	125	Kansas City
O'Hearne, John J	125	Kansas City
Ohlms, David L	190	St. Louis
Ojascastro, Alejandro C	190	St. Louis
Ojascastro, Lou	190	St. Louis
Oleson, Gale B	125	Blue Springs
Olive, G. Chapman	082	Springfield
Olive, George C	166	Neosho
Olive, Paul M	082	Springfield
Oliver, G. Charles	002	St. Louis
Oliver, George A	138	Farmington
Olk, R. Joseph	002	Chesterfield
Olsen, Teresa A	082	Springfield
Olson, E. Rule	082	Springfield
Olson, Gary S	042	Cape Girardeau
Olson, James H	050	Liberty
Olson, John P	030	St. Joseph
Olson, Richard O	189	St. Charles
Olson, Robert J	082	Springfield
O'Keefe, James H, Jr.	125	Kansas City
O'Malley, James F	125	Leawood, KS
Omell, Gary H	190	St. Louis
Onder, Robert F	190	St. Louis
O'Neal, Lawrence W	190	St. Louis
O'Neil, Jerome H, Jr.	190	St. Louis
Ong, Eng L	190	St. Louis
Ong, Ofelia S	190	St. Louis
Onken, Henry D	190	St. Louis

Oppenheimer, Henry E	**190**	St. Louis
Opper, Susan E	**125**	Kansas City
Oppermann, Karen J	**125**	Independence
Orgel, S. Michael	**190**	St. Louis
Orlando, Louis A	**125**	Kansas City, KS
Oro, John J	**026**	Columbia
O'Rourke, James E	**174**	Ste. Genevieve
Orr, Robert M	**125**	Kansas City
Orsay, Paul K	**190**	Chesterfield
Ortbals, David W	**190**	Chesterfield
Orth, O. Gerald	**026**	Columbia
Ortiguero, Leopoldo M	**190**	St. Louis
Ortmeyer, Leroy F	**190**	St. Louis
Osbourn, Richard A	**038**	Fulton
Ossman, Julian A	**058**	Jefferson City
Ost, Mark D	**125**	Kansas City
Ostapowicz, Frank	**190**	St. Louis
Ostergaard, Daniel J	**125**	Kansas City
Ostrow, Bridget F	**042**	Cape Girardeau
Ostrow, Louis B	**042**	Cape Girardeau
O'Sullivan, Daniel F	**190**	St. Louis
Ota, David M	**026**	Columbia
Othmer, Ekkehard	**050**	Kansas City
Otis, Stephanie A	**002**	St. Louis
O'Toole, Lisa	**125**	Overland Park, KS
O'Toole, Patrick M	**125**	Kansas City
Ott, F. Thomas	**190**	St. Louis
Ott, Harold J	**190**	St. Louis
Ott, William J	**190**	St. Louis
Otto, William J	**082**	Springfield
Ouellette, David F	**150**	Hannibal
Ovens, Lisa	**082**	Springfield
Overend, Don S	**082**	Springfield
Overesch, Harry B	**125**	Kansas City
Owen, Robert F	**190**	St. Louis
Owens, Robert H	**125**	Shawnee Mission, KS
Owens, William D	**190**	St. Louis
Ozar, Milton B	**125**	Miami, FL
Ozenberger, Larry A	**054**	Plattsburg

P

Pacheco, Jose M	**082**	Springfield
Packman, Paul	**190**	St. Louis
Packman, Robert C	**190**	St. Louis
Padilla, Teresita C	**190**	Chesterfield
Padula, Richard T	**125**	Shawnee Mission, KS
Paez, Mauro A	**190**	St. Louis
Paff, David G	**082**	Springfield
***Page, Lawrence V**	**102**	Joplin
Painter, Andrew E	**202**	Portageville
Painter, Lattie B	**170**	Portageville
Palazola, Joseph M	**125**	Kansas City
Palcheff, Chris L	**082**	Springfield
Palen, James E	**042**	Cape Girardeau
Palenske, Robert L	**070**	Hornersville
Paletta, Francis X, Sr.	**190**	St. Louis
Paletta, Frank	**190**	St. Louis
Paletta, Victor L	**190**	Bridgeton
***Palmer, Allen S**	**190**	Bridgeton
Palmer, Stephen M	**190**	St. Louis
Pancoast, Charles H	**042**	Cape Girardeau
Paone, Douglas B	**125**	Kansas City
Papreck, K T	**198**	Marshall
Paradelo, Jorge C	**125**	Kansas City
Parikh, Sharad P	**190**	Florissant
Paris, William H	**190**	Bridgeton
Park, Bert E	**082**	Springfield
Park, Duk J	**106**	Festus
Park, Kee B	**042**	Cape Girardeau
Park, William I, Jr	**082**	Springfield
Parker, Arthur C	**034**	Destin, FL
Parker, Brent M	**026**	Colorado Springs, CO
Parker, Craig A	**125**	Kansas City
Parker, Jeffrey W	**026**	Columbia
Parker, Kim E	**125**	Kansas City
Parker, Thomas W	**190**	St. Louis
Parkins, George K	**125**	Kansas City
Parks, Charles	**190**	St. Louis
Parks, David A	**215**	St. Louis
Parks, Deborah L	**190**	St. Louis
Parks, Jon C	**034**	Poplar Bluff
Parks, Joseph J	**026**	Jefferson City
Parks, William C	**026**	Columbia
Parres, Jeffrey A	**190**	St. Louis
Parsons, Clyde W, III	**082**	Springfield
Partamian, Krikor O	**030**	St. Joseph
Parulekar, Dilip G	**038**	Fulton
Parwatikar, Sadashiv D	**190**	St. Louis
Paskar, Larry D	**190**	Chesterfield
***Pasowicz, Timothy C**	**215**	Shawnee Mission, KS
Passanante, Bartholomew M	**190**	St. Louis
Patel, Ashokkumar B	**190**	St. Louis
Patel, Bipin T	**030**	St. Joseph
Patel, Indu B	**106**	Barnhart
Patel, Raman J	**030**	St. Joseph
Patel, Yogesh P	**215**	Fenton
Patrick, Roman L	**190**	St. Louis
Patterson, Alec	**002**	St. Louis
Patterson, Donald C	**026**	Columbia
Patterson, Donald R	**102**	Joplin
Patterson, Grover S	**102**	Carthage
Patty, Carl F	**034**	Poplar Bluff
***Patty, John R**	**034**	Poplar Bluff
Paulson, Gordon S	**030**	St. Joseph
Pavelonis, Joel D	**002**	Kansas City
Pavlovich, Andrew S	**125**	Independence
Pavlu, Robert R	**118**	Waverly
Pawsat, John E	**125**	Kansas City
Payne, David E	**026**	Columbia
Payne, Meredith C	**190**	Chesterfield
Pearce, Eugene W. J.	**125**	Kansas City
Pearman, Carl C	**002**	Kansas City
Pearse, Carlton S	**190**	Chesterfield
Pearson, Thomas C	**082**	Springfield
Pearson, William E	**190**	St. Louis
Peck, William A	**190**	St. Louis
Peden, Virginia H	**190**	Maryland Hghts
Pehlman, Joseph E	**070**	Malden
Peick, Ann C	**034**	Poplar Bluff
Pelican, George	**190**	St. Louis
Pendell, Paul W	**125**	Raymore
Penilla, Antonio R	**190**	St. Louis
Pennell, Richard C	**190**	St. Louis
Penninger, William H	**082**	Springfield
Pennington, Michael S	**166**	Springfield
Pennoyer, James	**190**	St. Louis
Pentella, Karen J	**190**	St. Louis
Peplinski, Gary R	**215**	St. Louis
Pepose, Jay S	**002**	St. Louis
Pepper, Edward G	**190**	St. Louis
Pereira, MaryBeth	**190**	St. Louis
Perez, Adamor R	**190**	St. Louis
Perez, Blanca M	**190**	St. Louis
Perez, Carlos A	**190**	St. Louis
Perez, Robert J	**190**	St. Louis
Perinetti, Enrique P	**190**	St. Louis
Perkins, David E	**190**	Chesterfield
Perll, Maurice F, Jr.	**125**	Kansas City
Perll, Michael F	**125**	Kansas City
Perll, Peter D	**014**	Mexico
Perlmutter, John C	**189**	St. Charles
Perna, Vincent P	**189**	St. Louis
Pernoud, Flavius G, III	**190**	St. Louis
Pernoud, Flavius G, Jr.	**190**	St. Louis
Pernoud, Joan M	**190**	St. Louis
***Perry, Christopher M**	**002**	St. Louis
Perry, Michael C	**026**	Columbia
Perryman, Douglas R	**125**	Kansas City

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Perryman, J. Chris	125	Kansas City
Perryman, Kathy M	125	Kansas City
Petelin, Joseph B	125	Shawnee Mission, KS
Peters, Walter R	026	Columbia
Petersen, James H	002	Chesterfield
Petersen, Larry D	082	Springfield
Peterson, Carl M	125	Kansas City
Peterson, Charles R	120	Osage Beach
Peterson, Craig A	082	Springfield
Peterson, Frederick D	190	St. Louis
Peterson, Ila M	125	Overland Park, KS
Peterson, Jay T	125	Kansas City
Peterson, Stanley S	082	Springfield
Peterson, Stephen E	125	Kansas City
Peterson, Walter R	125	Kansas City
Petit, Carl A	120	Osage Beach
Petkovich, Frank O	190	St. Louis
Pettett, Gary	125	Kansas City
Pew, Becky A	190	St. Louis
***Pewitt, Charles S**	042	Jackson
***Pfautsch, Mark L**	042	Cape Girardeau
Pfefer, Leland U	026	Columbia
Pfefferkorn, David A	202	Sikeston
Phelan, Christie B	125	Kansas City
Phelan, David	125	Independence
Phillips, Abraham M	190	St. Louis
Phillips, Daniel	190	St. Louis
Phillips, Granville J	110	Warrensburg
Phillips, John J	190	Florissant
Phillips, Kenneth D	042	Cape Girardeau
Phillips, Robert L	215	Columbia
Phillips, Ronald L	148	Kirksville
Phillips, Thomas P	125	Kansas City
Phillips, William J	190	Chesterfield
Philpott, Gordon W	190	St. Louis
Phipatanakul, Supote	190	Kirkwood
Piccirillo, Jay F	190	St. Louis
Pickard, Clarence M	026	Columbia
Pickens, Andrew T	190	St. Louis
Picker, Selwyn	190	St. Louis
Pickering, Lee I	125	Independence
Picus, Joel	002	St. Louis
Piebenga, Larry W	125	Kansas City
Piehler, Jeffrey M	125	Kansas City
Piening, Kurt A	189	St. Charles
Pierce, Dan L	026	Columbia
Pignotti, Blase J	190	St. Louis
Piker, K. Dewayne	082	Springfield
Pimentel, Esperanza M	190	St. Louis
Pinckley, James N	082	Springfield
Pineda, Hector O	190	St. Louis
Pineda, Juan J	215	Columbia
Pingelton, William B	026	Columbia
Pinkerton, Joe A, Jr.	125	Kansas City
Pinkham, Chris M	050	Kansas City
Pintado, Susan O	102	Joplin
Piontek, James F	050	Liberty
Piontek, Jerome G	190	Chesterfield
Piper, Terrence L	189	St. Peters
Pitiyanuvath, Tasanaporn	125	Kansas City
Pitney, Phillip W	150	Louisiana
Pitsinger, N. Bruce	190	Chesterfield
***Pitt, James B**	120	Osage Beach
Pittman, David L	026	Columbia
Pittman, Gerald R	190	St. Louis
Pittmann, Thomas	190	St. Louis
Pitts, Olevia	125	Overland Park, KS
Place, Kenneth C	125	Kansas City
Plax, Steven I	190	St. Louis
Plowman, Edward M	150	Hannibal
Podolsky, Howard S	002	St. Louis
Podrecca, Guido I	082	Key Largo, FL
Poger, Marshall E	190	St. Louis
Poggemeier, David A	189	St. Charles
Poggemeier, William H	189	St. Charles
Pogson, George W, III	125	Independence
Pohl, David L	190	St. Louis
Pojanasomboon, Pichat	135	Rolla
Politi, Gregory B	125	Kansas City
Politte, Lenard L	026	Columbia
Pomeranz, Howard D	215	St. Louis
Pomphrey, Martin M, Jr.	190	Chesterfield
Pon, Marcelino	190	St. Louis
Ponstingl, Raana J	190	St. Louis
Pontillas, Job B	174	Perryville
Poole, Anthony G	202	Sikeston
Porte, Karen L	102	Joplin
Porter, Charles B	125	Kansas City
Porter, Michael J	125	Kansas City
Porter, Susan S	125	Kansas City
Portnoff, Lee S	190	St. Louis
Posey, Douglas H, Jr.	030	St. Joseph
Post, Stephen L	190	St. Louis
Postma, George S, Jr.	125	Mission, KS
Potashnick, Robert	190	St. Louis
Pottenger, L. Kenneth	102	Joplin
Potter, Caryl A, Jr	030	St. Joseph
Potter, Reese H	190	St. Louis
Potts, Dan E	190	Chesterfield
Potts, Donald A	125	Kansas City
Potts, Fred E, III	082	Strafford
Potts, Gregory A	074	Washington
***Pourakbar, Mohammad K**	215	Kansas City
Powell, Alan E	125	Independence
Powell, Edwin M	082	Springfield
Powell, John A	190	St. Louis
Powell, Kenneth R	082	Springfield
Powell, Lisa G	082	Springfield
Powers, Catherine A	125	Leawood, KS
Prater, Bill G	082	Springfield
Prater, Thomas G	082	Springfield
Prelutsky, David J	190	St. Louis
Prensky, Arthur L	190	St. Louis
Presley, Jimmy C	082	Springfield
Preston, Bruce E	206	West Plains
Presutto-Nelson, Kathleen A	082	Springfield
Previti, Vincent	082	Springfield
Prey, Marianne U	190	St. Louis
Pribor, Elizabeth F	190	Chesterfield
Prica, George, Jr	026	Columbia
Price, Carl I	082	Springfield
Price, Hilton I	190	St. Louis
Price, Patrick K	125	Shawnee Mission, KS
Price, Richard C	214	Harrisonville
Prickett, David C, Jr	050	Kearney
Pringle, Scot G	042	Cape Girardeau
Pro, John D	125	Kansas City
Proctor, Donald C	178	Sedalia
Proskey, Vincent J	190	Chesterfield
Prstojevich, Steven J	125	Kansas City
Pruett, Burchard S	190	Prescott, AZ
Pruett, Don S	190	St. Louis
Pruett, Paul L	082	Springfield
Pryor, Carolyn J	190	Florissant
Pryor, Harold J	125	Kansas City
Pryor, Ira Joe	102	Joplin
Psaltis, Phillip E	030	Kansas City
Puckett, Charles L	026	Columbia
Puckett, Lynn M	026	Columbia
Pugh, Richard G	125	Blue Springs
Purcell, Henry E	190	St. Louis
Purcell, John J, Jr.	190	St. Louis
Purcell, Paul W	050	Renton, WA
Purcell, Richard D	082	Springfield
Puro, Edward A	190	Florissant
Putnam, John L	082	Springfield
Pyeatte, Jacob P, Jr.	042	Cape Girardeau
Pyszczynski, Dennis R	125	Kansas City

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Q

Quer, Erich A La Quinta, CA	**125**
Quick, William W Kansas City	**125**
Quinn, Paul S Strafford	**082**
Quinn, Rodney D Springfield	**082**
Qureshi, Abdul R St. Louis	**190**

R

Rabang, Lazaro U Bethany	**078**
Raborar, Arteso C Springfield	**082**
Racela, Luz S Leawood, KS	**125**
Rader, Ada E Kansas City	**125**
Rader, Edward S St. Louis	**190**
Radford, Diane M St. Louis	**190**
***Radinsky, Stephen** St. Louis	**190**
Ragland, John E Bonnots Mill	**058**
Rahman, Moududur Chesterfield	**190**
Rajcher, Wilma J Columbia	**026**
Raju, Niranjana Ste. Genevieve	**174**
Rall, Kenneth L Independence	**026**
Ramey, Ehret O Kansas City	**125**
Ramirez, Ricardo M Kansas City	**034**
Ramirez, Samuel G St. Louis	**190**
Ramos, Americo G Shawnee Mission, KS	**125**
Ramos, Richardo R St. Louis	**190**
Ramsey, J. Darryl Cape Girardeau	**042**
***Ramsey, Jesse R** Cape Girardeau	**042**
Ramsey, Robert H Florissant	**190**
Randolph, Bernard C, Jr. Bridgeton	**002**
Randolph, Bernard C St. Louis	**190**
Randolph, Kerry A Springfield	**082**
Ranginani, Anil K Savannah	**010**
Rangineni, Rajagopal St. Joseph	**030**
Rankin, Diane St. Louis	**190**
***Rankin, W. Dale** Joplin	**102**
Rao, Ricardo Chesterfield	**190**
Rao, Sumati St. Louis	**190**
Rao, Vijaya Kumar P Joplin	**102**
Rapp, Earl L Hannibal	**150**
Rappold, Henry O Chesterfield	**190**
Ratcliff, Keith M Washington	**074**
Ratkin, Gary A St. Louis	**190**
Ratnam, Dasari V Kansas City	**125**
Rau, Michael E Washington	**074**
Rawlins, Fred E Cape Girardeau	**042**
Rawson, Perry G Washington	**074**
Ray, Larry D Olathe, KS	**125**
***Ray, Terry L** Columbia	**026**
Raybould, Michael W Kansas City	**125**
Raynor, Richard C Marshall	**198**
Razzaq, A. St. Louis	**190**
Reaney, John A Kansas City	**125**
Rearden, Timothy P St. Louis	**190**
Reardon, James P N. Kansas City	**050**
Reardon, Thomas F St. Louis	**190**
Reardon, Thomas M N. Kansas City	**050**
Rector, Joe L Shawnee Mission, KS	**125**
Reddy, Abbiah N Poplar Bluff	**034**
Reddy, Agara S Columbia	**026**
Reddy, Anchala N West Plains	**206**
Reddy, Nalini A West Plains	**206**
Reddy, R. Ramachandra Cape Girardeau	**042**
Redfern, David L Springfield	**082**
Redington, James C N. Kansas City	**050**
Redington, James C, Jr. St. Louis	**190**
Redmon, Conchita M Springfield	**082**
Rednam, Krishnarao V Kirkwood	**190**
Reed, Glen H Appleton City	**214**
Reed, Jonathan R St. Louis	**190**
Reed, Timothy F Sedalia	**178**
Reeder, Charles C Smithville	**050**
Reeder, Stephen M Springfield	**082**
Reese, Jon A Springfield	**082**
Reese, Lester T St. Louis	**190**
Reeves, R. Bradley Joplin	**102**
Reeves, Col., Glen I Chevy Chase, MD	**190**
Regas, Stephen L Kansas City	**215**
Reh, Edward P, Jr. St. Louis	**190**
Reh, Thomas E St. Louis	**190**
Reichert, Timothy J St. Louis	**190**
Reifeiss, Jerry S Campbell	**070**
Reinhard, Edward H St. Louis	**190**
Reinhardt, J. Robert R Kansas City	**125**
Reinsvold, Thomas M Joplin	**102**
Reintjes, Stephen L Kansas City	**125**
Reiss, Jeanne E Kansas City	**125**
Reister, Philip D Kansas City	**125**
Rejent, Anthony J St. Louis	**190**
Rendleman, George F, Jr. St. Louis	**190**
Rengachary, Dhanalakshmi Kansas City	**125**
Rennard, Marvin St. Louis	**190**
Renner, Gregory J Columbia	**026**
***Reno, Lisa K** Lamar	**018**
Repp, Theodore J, Jr. St. Louis	**190**
Retter, Kenneth W Cape Girardeau	**042**
Reust, Carin E Springfield	**082**
Revare, Paul Kansas City	**050**
Revels, Harry R, III Leawood, KS	**125**
Reyes, Jose T St. Louis	**190**
Reyes, Lirio M Springfield	**082**
Reyes, Luis A Arnold	**190**
Reynolds, James A Chesterfield	**190**
Reynolds, Robert B, Sr. Carbondale, CO	**190**
Reynolds, Susan K St. Louis	**190**
Reynolds, William R Springfield	**082**
Rezvani, Laghaieh Sikeston	**202**
Rhee, Seoung E St. Louis	**190**
Rhoades, Charles E Kansas City	**125**
***Rhoads, Mark D** Joplin	**102**
Riaz, M. Afzal Ste. Genevieve	**174**
Ribaudo, J. Michael St. Louis	**190**
Ricci, Walter J Kansas City	**125**
Ricci, Walter F Shawnee Mission, KS	**125**
Rice, Karen H Jefferson City	**058**
Rice, Kathleen G Springfield	**082**
Rice, Lee Roy Joplin	**102**
Rice, Valerie M Kansas City, KS	**050**
Rich, Keith M St. Louis	**190**
Rich, Margaret M St. Louis	**190**
Richards, Dean D, III Kansas City	**125**
Richards, Frank O St. Louis	**190**
Richardson, Curtis J St. Joseph	**030**
Richardson, Donna T Union	**074**
Richardson, George A Union	**074**
Richardson, Marion W Kansas City	**125**
Richardson, Norbert L Union	**074**
Richardson, Thomas F St. Louis	**190**
Richardson, William R Union	**074**
Richert, Robert C Kansas City	**125**
Richmond, Ron Cape Girardeau	**042**
Ridenhour, C. E. Gene Columbia	**026**
Ridenour, Brock D St. Louis	**190**
Ridgeway, William G St. Louis	**190**
Ridings, Harold D Cape Girardeau	**042**
Riechers, Thomas B Washington	**074**
Rieger, Frank G Columbia	**026**
Ries, Douglas A Chesterfield	**190**
Rigden, L. Brick N. Kansas City	**125**
Rikli, Arthur E Columbia	**026**
Riley, Charles T Richmond	**118**
Riley, Joel Y St. Louis	**002**
Rinck, Edward C Nevada	**214**
Rinehart, Gregory C St. Louis	**190**
Riner, Ronald N St. Louis	**190**
Ring, Daniel S St. Louis	**215**
Ringer, C. Nelson Cape Girardeau	**042**
Riojas, Lisa A Rolla	**135**
Rippe, William F St. Joseph	**030**

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***Ripperger, Kevin L**	Springfield	082
Rising, Dean R	Springfield	082
Rispler, David T	Jefferson City	058
Ritter, C J	Cape Girardeau	042
Ritter, Carl F	Cape Girardeau	042
Ritter, Hubert A	St. Louis	190
Ritter, John L	Springfield	082
Ritter, R. August, III	Cape Girardeau	042
Ritter, Ray A, Jr	Cape Girardeau	042
Ritter, Raymond A, Sr.	Cape Girardeau	042
Rizzo, Adolfo E	St. Charles	190
Roa, Necita L	St. Louis	002
Roach, Mona S.I.	Prairie Village, KS	125
Robbins, Philip L	St. Louis	190
Robbins, Thomas D	Jefferson City	058
Roberts, Charles C	Kansas City	125
Roberts, Christopher H	Joplin	102
Roberts, Grosvenor G	Kansas City	125
Roberts, Harold K	Clayton	190
Roberts, Howard H	Joplin	102
Roberts, Jonathan M	Jefferson City	058
Roberts, Perry T	Oxford, MS	042
Roberts, Phyllis G	St. Joseph	030
***Roberts, Rebecca L**	Kansas City	030
Roberts, Theodore W	Sikeston	202
Robertson, Frank G	Cuba	190
Robertson, Terence A	Kansas City	125
Robertson, William D	Poplar Bluff	034
Robinett, Wade V	Kansas City	125
Robinow, Jay S	Kansas City	125
Robinson, Arthur W	Shawnee Mission, KS	125
Robinson, Gary L	Springfield	082
Robinson, Gordon H	St. Louis	190
Robinson, James C	Columbia	026
Robinson, Jay G	Kansas City	125
Robinson, Nicholas F	Kennett	070
Robinson, Ronald L	Cape Girardeau	042
Robinson, Van M	Carefree, AZ	198
Robinson, William A	Kansas City	125
Robinson, William J	Overland Park, KS	125
Robison, Paul D	Joplin	102
Rodefeld, Mark D	St. Louis	215
Rodgers, Dorothy L	Columbia	026
Rodgers, George H	Leawood, KS	125
Rodgers, Saml U	Kansas City	125
Rodrigo, Bernardo R	St. Louis	190
Rodriguez, Gregorio L	Charleston	202
Rodriguez, Ubaldo R	St. Louis	190
Roehrs, Marvin E	Marshall	198
Rogers, Casey	Mexico	014
Rogers, David B	Springfield	082
Rogers, H. Bryan	St. Louis	190
Rogers, James T	Springfield	082
Rogers, James D	Springfield	082
Rogers, Jerry B	Springfield	082
Rogers, John T	St. Joseph	030
Rogers, Joseph Drewry	Springfield	082
Rogers, Robert L	Kansas City	125
Roh, Joseph J	Kansas City	125
Roh, Lynn H	Kansas City	125
Roller, James A	Columbia	026
Rollo, John L	St. Louis	190
Romaker, Ann M	Kansas City	125
Romkema, George E	St. Louis	190
Roper, Charles L	St. Louis	190
Rose, Barry A	Overland Park, KS	125
Rosecan, Marvin	Belleville, IL	190
Roselman, Michael J	Springfield	082
Rosen, Howard M	N. Kansas City	125
Rosen, Larry A	Independence	125
Rosen, William K	Springfield	082
Rosenbaum, Herbert E	St. Louis	190
Rosenberg, David S	Florissant	190
Rosenbloom, Michael	St. Louis	190
Rosenthal, Debra D	St. Louis	190
Rosenthal, Howard G	Kansas City	125
Rosenthal, Randall	St. Louis	190
Rosenthal, William N	Kansas City	125
Roshan, Bijan	Mission, KS	215
Ross, Gilbert, Jr.	Columbia	026
Ross, William J	Bridgeton	190
Roter, Alexander M	St. Charles	189
Roth, Alfred D	Mission, KS	125
Roth, John J	St. Louis	190
Rother, Paul H	St. Charles	189
Rotskoff, Kenneth S	St. Louis	190
Rottler, Paul D	St. Louis	190
Rouse, Ernest T	St. Louis	190
Rouse, Ernest T, III	St. Louis	190
Roush, Randall D	Florissant	190
***Routsong, Rodney T**	St. Louis	190
Roxas, Generoso P	St. Charles	189
Roy, Tapankumar S	St. Louis	190
Royce, Debra L	Sarcoxie	102
Rozen, Jay I	Kansas City	125
Rubin, Brian G	St. Louis	002
Rucker, Walter W	Kansas City	215
Ruehl, Albert F	St. Louis	190
Rues, Lawrence A	Kansas City	125
Ruess, Robert W	Cape Girardeau	042
Ruff, Paul G	Springfield	082
Ruhling, Rudy	Punta Gorda, FL	190
Rul-Lan, Carlos D	Kansas City	002
Rumpf, Ronald P	Columbia	026
Runez, Manuel W	Maryville	158
***Rupright, S. Jon**	Columbia	058
Rush, Marvin R	Ste. Genevieve	174
Russell, Garth S	Columbia	026
Russell, James L	Kansas City	125
Russell, John J	Cape Girardeau	042
***Russell, Robert B**	Cape Girardeau	042
Russell, Robert K	Kansas City	125
Russell, Steven L	Kansas City	050
Rutherford, Barry D	Kansas City	125
Ruwitch, Joseph F, Jr.	St. Louis	190
Ryall, Jo-Ellyn M	St. Louis	190
Ryan, David	Trenton	078
Ryan, Robert A	Mission, TX	082
Ryan, Robert E, Sr.	Chesterfield	190
Ryan, Thomas J	Jefferson City	058
Rymer, Marilyn M	Kansas City	125

S

Sabates, Felix N, Sr.	Prairie Village, KS	125
Sabates, Nelson R	Prairie Village, KS	125
Sabates, Roland	Kansas City	125
Sabet, Abdollah A	Ballwin	190
Saboeiro, Gregory R	St. Louis	002
***Sacha, Robert F**	Cape Girardeau	042
Sachar, Jerome D	St. Louis	190
Sadhu, Vijay K	Columbia	026
Saferstein, A L	Shawnee Mission, KS	125
Safley, Thomas J	Independence	125
Saghir, Marcel T	St. Louis	190
Saha, Nitai C	St. Louis	190
Saha, Sudha R	St. Louis	190
Sahebjamei, Tannaz	Kansas City	215
Sahota, Pradeep K	Columbia	026
Sakmar, Douglas A	St. Louis	190
Sale, Llewellyn, Jr.	St. Louis	190
Salibi, Habbouba	Chesterfield	190
Salmon, M. L.	Palm Harbor, FL	190
Salvador, Antonio	St. Louis	190
Samet, John M	St. Louis	190
Sammon, T. James	Springfield	082
Samson, Barry L	St. Louis	190
Samudrala, Ramulu	St. Louis	190
Samuel, George P	Doniphan	034

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Samuelson, Thomas S	**125**	Kansas City
Sanchez, Jon J	**082**	Springfield
Sanders, Harold L	**026**	Columbia
Sanders, Jack S	**058**	Jefferson City
Sanders, William F	**125**	Kansas City
Sandiford, Patrick	**189**	St. Charles
Sandow, Theodore L	**125**	Kansas City
Sandza, Joseph G, Jr.	**190**	Des Peres
Saneman, Paul P	**102**	Joplin
Sanfelippo, John F	**058**	Jefferson City
Santanello, William M	**190**	Belleville, IL
Sargent, Alden P	**202**	Sikeston
Sarma, Anuradha H	**125**	Lee's Summit
Sasser, William F	**190**	St. Louis
Sato, George	**190**	Chesterfield
Sato, Richard W	**190**	Chesterfield
Satterlee, C. Craig	**125**	Kansas City
Sauer, Gordon C	**125**	Kansas City
Sauer, James M	**082**	Springfield
Savci, Hasan D.	**190**	St. Louis
Sawyer, Floyd E	**050**	Ft. Lauderdale, FL
Sawyer, James	**190**	St. Louis
Scacewater, Rick	**102**	Joplin
Scarborough, Betty F	**125**	Shawnee Mission, KS
Scarborough, Mark R	**125**	Kansas City
Scearce, Robert L	**058**	Jefferson City
Schaaf, Robert O	**030**	St. Joseph
Schabbing, Mark B	**215**	Columbia
Schaberg, James E	**189**	St. Charles
Schaberg, Kevin B	**190**	Chesterfield
Schaefer, Glennon S	**190**	St. Louis
Schaeffer, Edward M	**082**	Springfield
Schaerer, Jacques P	**190**	St. Louis
Schane, Catherine L	**082**	Springfield
Schanzlin, David J	**190**	St. Louis
Schaper, Ernest H	**190**	St. Louis
Scharf, Daniel	**125**	Overland Park, KS
Scharrer, Alan J	**002**	Lee's Summit
Scheibe, Robert G	**190**	St. Louis
Scheible, Robert F	**190**	St. Louis
***Schekorra, Fred W**	**058**	Camdenton
Schell, James A	**026**	Columbia
Scheperle, Mark A	**190**	St. Louis
Scherer, Stephen	**125**	Kansas City
Scheu, James H	**190**	St. Peters
Schewe, Elmer J	**026**	Columbia
Schierman, William D	**190**	St. Louis
Schiffmacher, Jack E	**125**	Prairie Village, KS
Schillie, Gene A	**125**	Kansas City
Schlafly, Bruce S	**190**	St. Louis
Schlafly, Edward F, Jr.	**190**	Chesterfield
Schlansky, Howard J	**189**	St. Charles
Schlansky, Seymour M	**190**	St. Louis
Schlarman, David E	**190**	St. Louis
Schleicher, Paul J	**215**	Kansas City
Schlossman, David M	**026**	Columbia
Schlozman, Danl L	**125**	Kansas City
Schmaltz, Richard A	**026**	Columbia
Schmid, Tania L	**190**	St. Louis
Schmidt, Dennis A	**190**	St. Louis
Schmidt, Edwin H, III	**190**	St. Louis
Schmidt, Edwin H	**190**	St. Louis
Schmidt, Herbert J	**102**	Joplin
Schmidt, Jerome H	**058**	Jefferson City
Schmidt, Martin P	**190**	St. Louis
Schmidt, Thomas L	**125**	Kansas City
Schmitz, John M	**125**	Kansas City
Schmitz, Ralph A	**166**	Monett
Schnarr, William	**189**	St. Charles
***Schneider, Horace L**	**042**	Cape Girardeau
Schneider, J. Michael	**082**	Springfield
Schneider, Paul G	**190**	St. Louis
Schneider, Robert J	**190**	St. Louis
Schneider, Thomas A	**189**	St. Charles
Schnurr, Thomas C	**058**	Jefferson City
Schoch, Lawrence H	**190**	Florissant
Schoedinger, George R, III	**190**	St. Louis
Schoenecker, Perry L	**190**	St. Louis
***Schoenfeld, Roger H**	**102**	Joplin
Schoengarth, Lowell D	**026**	Columbia
Schondelmeyer, R. Wade	**026**	Columbia
Schoolman, Arnold	**125**	Kansas City
Schopp, Alvin C	**190**	St. Louis
Schottman, Gerhard W	**125**	Shawnee Mission, KS
Schreiber, David J	**190**	Alton, IL
Schrenk, Loren C	**002**	St. Louis
Schrick, Richard E	**190**	St. Louis
Schroeder, Walter A, Jr.	**042**	Cape Girardeau
Schroer, William C	**002**	Bridgeton
Schroff, Carle E	**082**	Springfield
Schuessler, Edward C	**190**	St. Albans
Schuessler, Wolfgang P	**190**	St. Louis
Schuetz, Alfred	**189**	St. Charles
Schuetz, Evelyne G	**189**	St. Charles
Schuh, Marlys E	**190**	Creve Coeur
Schultz, Earl R	**190**	St. Louis
Schultz, Irwin	**190**	St. Louis
Schulz, Richard C	**190**	St. Louis
Schutz, John P	**050**	Excelsior Springs
Schwartz, Henry G	**190**	St. Louis
Schwartz, Howard R	**082**	Springfield
Schwartz, Howard I	**125**	Kansas City
Schwarz, Luis H	**190**	St. Louis
Schwarze, Daniel J	**190**	St. Louis
***Schwarze, Martin W**	**190**	St. Louis
Schwegler, Robert G	**125**	Shawnee Mission, KS
Schweiss, John F	**190**	St. Louis
Scodary, Daniel J	**190**	Bridgeton
Scott, Andrew	**125**	Kansas City
Scott, C. Alan	**198**	Marshall
Scott, E. David	**058**	Jefferson City
Scott, Elwin P	**190**	Sun City, AZ
Scott, Hillard L	**190**	St. Louis
Scott, Janie A	**082**	Springfield
Scott, Joni C	**082**	Springfield
Scott, Kenneth F	**086**	Clinton
Scott, Michael R	**082**	Springfield
Scott, Robert W	**082**	Springfield
Scott, Wendell J	**082**	Springfield
Scowley, John E	**118**	Richmond
Scully, Thomas F	**190**	St. Louis
Seabaugh, Janice L	**042**	Cape Girardeau
Seabaugh, William L	**042**	Cape Girardeau
Seaberg, John J, III	**026**	Columbia
Seagrave, Richard A	**082**	Springfield
Seale, Stuart A	**082**	Springfield
Sears, John	**215**	Columbia
Sedgwick, William G	**190**	St. Louis
See, W. Mike	**026**	Columbia
Seeck, Linda E	**074**	Washington
Seelig, Robert D	**002**	St. Louis
Segraves, Steven D	**125**	Kansas City
Seiden, Gerald D	**125**	Kansas City
Seitz, Elson F	**125**	Independence
Selhorst, John B	**190**	St. Louis
Selove, Peter T	**102**	Joplin
Sertl, George O	**190**	St. Louis
Sertl, James F	**190**	St. Louis
Sessions, Donald G	**190**	St. Louis
Severance, Michael S	**058**	Jefferson City
Shaeffer, James T	**082**	Springfield
Shaffer, William O	**190**	St. Louis
Shagets, Frank W	**102**	Joplin
Shah, Anwar	**190**	St. Louis
Shah, Jitendra P	**190**	St. Louis
Shah, Ramesh R	**102**	Joplin
Shah, Riaz H	**014**	Mexico
Shah, Sheila	**030**	St. Joseph

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Shaheen, Eleanor	Columbia	026
Shakil, Mohammad	Cape Girardeau	042
Shalet, Malcolm F	Kansas City	125
Shanahan, Mary P	Joplin	102
Shanahan, Philip J	St. Louis	190
Shands, Courtney, III	St. Louis	190
Shane, Ramon A	Springfield	082
Shaner, Thomas P	St. Louis	190
Shank, Robert E	St. Louis	190
Shapero, James A	Columbia	026
Shapleigh, John B, II	Chesterfield	002
Shaplin, Alfred D	Ballwin	106
Sharlow, Joseph W	Ste. Genevieve	174
Sharma, Vidya	Kansas City	125
Sharp, Ronald J	Overland Park, KS	125
Shatley, Miriam J	Jefferson City	058
Shatz, Burton A	St. Louis	190
Shaw, Edward J	St. Louis	190
Shaw, James T	Hermann	074
Shaw, Richard C	St. Louis	190
Shaw, Robert D	Willow Springs	206
Shea, James G	Hobe Sound, FL	074
Sheahon, John A	Raytown	125
Shealy, C. Norman	Fair Grove	082
Shechter, Nathan	Kansas City	125
Sheehan, Michael B	Kansas City	125
Sheehan, Paul J	Bridgeton	190
Sheffner, Paul W	St. Louis	190
Shelden, Russell D	Kansas City	125
Sheley, James M	Springfield	082
Shell, William C	Sikeston	202
Shelley, William C	Kansas City	125
Shelton, Becky R	Chesterfield	190
Shelton, Earl W	Lake St. Louis	190
Shelton, R. Wayne	Springfield	082
Shen, Anthony S	St. Louis	190
Shen, Jerome T	St. Louis	190
Shen, Winston W	St. Louis	190
Sher, Allyn L	Columbia	026
Sheridan, John J	St. Louis	190
Sherman, David M	Springfield	082
Sherman, W. Gary	Chesterfield	190
Sherrod, Duane W	Joplin	102
***Sherrod, Glenn M**	Bridgeton	190
Sherwin, Charles S	St. Louis	190
Shevlin, Charles F	Palm Springs, CA	030
Shields, John B	St. Louis	190
Shields, Lawrence S	Springfield	082
Shifrin, Alexander	Kansas City	125
Shimshak, Thomas M	Kansas City	125
Shine, Thomas E	St. Louis	190
Shinn, Michael E	Kansas City	050
***Shipman, Wade M**	Rogersville	082
Shitut, Ravindra V	St. Louis	190
Shively, Robert A	St. Louis	190
Shniter, Lorinna	St. Louis	190
Shockley, Clarence J	Greenwood	125
***Shoop, Jill E**	Springfield	082
Shopper, Glenn K	Kansas City	125
Shopper, Moisy	St. Louis	190
Shore, Jeffrey L	Joplin	102
Short, Charles D	St. Louis	190
Short, Howard N	Washington	074
Shoss, Milton	Hilton Head Island, SC	042
Shoults, Nicholas F	Springfield	082
Shriver, Rebecca L	Kansas City	215
Shroff, Kumkum	St. Louis	190
Shuff, Paul D	St. Louis	190
Shuler, Frederick N	Kansas City	125
Shull, G D	Jefferson City	058
Shultz, Thomas M	Springfield	082
Shuman, Joseph S	St. Louis	190
Shuter, Eli	St. Louis	190
Shuttari, Mir F	St. Louis	190
Shyken, Herman	St. Louis	190
Sicard, Gregorio A	St. Louis	190
Sicat, Alfonso V	Warrensburg	110
Sides, Stanley D	Cape Girardeau	042
Siegel, Barry A	St. Louis	190
Siegel, Carl D	Kansas City	125
Siegel, Charles	Gladstone	050
Siegfried, Carla J	Ballwin	190
Siemer, Deanna M	Columbia	215
Siemers, George E	Naples, FL	190
Sigmund, Charles A	Bridgeton	190
Silbergeld, Daniel L	St. Louis	190
Siler, Thomas M	St. Charles	189
***Sill, William**	St. Peters	189
Silliman, York E	St. Joseph	030
Silsby, Harry D	Springfield	082
Silver, Bernd	St. Louis	190
Silver, Donald	Columbia	026
Silverberg, Charles	St. Louis	190
Silvers, L. Michael	Kansas City	125
Silverstein, Steven M	Kansas City	125
Simmons, Connie D	Cape Girardeau	042
Simmons, Donald D	Kansas City	125
Simmons, Jess S	Joplin	102
Simmons, John L	Vero Beach, FL	125
Simo, Frank	St. Louis	190
Simon, David L	St. Louis	190
Simon, Nathan M	St. Louis	190
Simon, Sanford	Kansas City	125
Simowitz, Fredric M	St. Charles	189
Simpson, Albert P	Springfield	082
Simpson, Joseph R	St. Louis	190
Sincox, Charles H	Washington	074
Sindhwani, Ravinder(Ravi) K	Louisiana	150
Singh, Daljeet R	Higginsville	118
Singh, Kuldeep	Macon	046
Singleton, Charles M, II	Kansas City	125
Singleton, John M, III	Kansas City	125
Singleton, Marvin A	Joplin	102
Siripipat, Pallop	Mexico	014
Sisten, Donald R	St. Louis	190
Sisson, Richard G	St. Louis	190
Sitzmann, Bryan L	Kansas City	050
Siu, Kenneth K C	Jefferson City	058
Sivarajan, Subramanian	Kansas City	125
Skeins, Edward J, Jr.	Springfield	082
Skelley, Mark J	Joplin	102
Skillman, Robert K	Shawnee Mission, KS	125
Skimming, W. Lee	St. Louis	190
Skinner, John S	St. Louis	190
Sklenar, Donald E	St. Joseph	030
Slack, Melinda R	Springfield	082
Slahorek, George J	St. Joseph	030
Slankard, J. Edward	Overland Park, KS	125
Slattery, Michael J	Kansas City	215
Slaughter, Carl R	Morrilton, AR	050
Slaughter, Larry	Columbia	026
Slentz, Edwin L	Shawnee Mission, KS	125
Sleuwen, Leslie	St. Louis	215
Slimack, Joseph P	Chesterfield	002
Slocum, Stephen G	St. Louis	190
Sly, Anne K	Kansas City	125
Smalley, Stephen R	Kansas City	125
Smalling, Ronnie G	Springfield	082
Smeltzer, Frederick M	Lake Ozark	120
Smid, Anne A	Springfield	082
Smid, David M	Springfield	082
Smiley, William L	St. Louis	190
Smith, Arnold L	Columbia	026
Smith, Arthur B	Philadelphia, PA	125
Smith, Benj F	St. Louis	190
Smith, Brenda S	Kansas City	125
Smith, Bruce D	St. Joseph	030
***Smith, C. Daniel**	St. Joseph	030

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***Smith, Charles H**	**050**	Gladstone
Smith, Claude F	**206**	Willow Springs
Smith, Courtland P, Jr.	**070**	Kennett
Smith, David Lambuth	**125**	Kansas City
Smith, Dermott A	**190**	St. Louis
Smith, Earl E, III	**190**	Bridgeton
Smith, Edward B	**125**	Kansas City
Smith, Emily L	**190**	St. Louis
Smith, Gilbert D	**034**	Poplar Bluff
Smith, Hubert E	**125**	Kansas City
Smith, Hugh R	**190**	St. Louis
Smith, Katherine W	**125**	Kansas City
Smith, Kathleen	**190**	DuQuoin, IL
Smith, Kenneth R, Jr.	**190**	St. Louis
Smith, Kenneth R	**206**	Bolivar
Smith, Kenneth B	**074**	Washington
Smith, Kristy	**215**	Kansas City
Smith, Norman A	**026**	Columbia
Smith, Patrick A	**026**	Columbia
Smith, Peter G	**190**	St. Louis
Smith, Porter	**070**	Poplar Bluff
Smith, Robert W	**190**	Chesterfield
Smith, Robert W	**078**	Brookfield
Smith, Roland T	**102**	Gulfport, MS
Smith, Sally L	**190**	Chesterfield
Smith, Timothy W	**125**	Kansas City
***Smith, Toni R**	**148**	Kirksville
Smith, Victorija L	**190**	Ballwin
Smith, W. Russell	**102**	Carthage
Smith, Wallace B	**125**	Independence
Smith, William J	**086**	Windsor
Smoller, Martin B	**189**	St. Louis
Snead, William H	**082**	Springfield
Sneid, David S	**125**	Kansas City
Snidle, William F	**106**	Crystal City
Snow, Emasue	**082**	Springfield
Snow, Jon F	**082**	Springfield
Snowden, Kent L	**190**	St. Louis
Snyder, Charles L	**125**	Overland Park, KS
Sobky, George H	**190**	Louisiana
***Soghrati, Naser O**	**215**	Kansas City
Soha, Joseph J, Jr.	**026**	Columbia
Sohn, Richard	**190**	St. Louis
Solanki, Nareshkumar J	**190**	Wentzville
Sollars, Eric G	**030**	St. Joseph
Solomon, Felix G	**190**	St. Louis
Solomon, Steven L	**190**	St. Louis
Soltys, Stephen M	**026**	Jefferson City
Sommer, Conrad S	**190**	St. Louis
Sommer, Rand W	**002**	St. Louis
Soonattrakul, Wuthisak	**070**	Kennett
Soorya, Narendir T	**190**	St. Louis
Sopuch, John A	**190**	St. Louis
Sosebee, Lee A	**026**	Hot Springs, AR
Sosna, Jacob P	**190**	St. Louis
Soucy, John C	**189**	St. Charles
Southwick, Christopher L	**026**	Columbia
Spadaro, James J	**190**	St. Louis
Spade, Diana J	**082**	Springfield
Spadone, Donald P	**026**	Columbia
Spaedy, Tony	**026**	Columbia
Spake, R. Vanneman	**125**	Kansas City
Spalding, David L	**082**	Springfield
Spalding, Donald G	**190**	St. Louis
Spalding, Martin	**215**	Columbia
Spalding, Wilber B, Jr.	**125**	Kansas City
Sparkman, Thomas C	**042**	Cape Girardeau
Spellman, Michael J, Jr.	**215**	St. Louis
Spence, Paul A	**042**	Cape Girardeau
Spence, Paul R	**215**	Kansas City
Spencer, Donald C	**026**	Fulton
Speno, Angelo A	**190**	St. Louis
Spernoga, John F	**190**	St. Louis
Spies, Barbara J	**125**	Louisburg, KS
Spinzig, Bruce D	**046**	Moberly
Spitler, Allen L	**042**	Cape Girardeau
Spivack, Alan R	**190**	Chesterfield
Sponenberg, Don D	**082**	Springfield
Sportsman, Weldon L	**050**	Kansas City
Sprague, Gita	**030**	St. Joseph
Spurgat, Robert M	**030**	St. Joseph
Spurgeon, Milo J	**026**	Columbia
Spurlock, Luther D	**135**	Rolla
Spurney, Joe E	**125**	Kansas City
Spurny, Otto M	**125**	Kansas City
Spurrier, Mark H	**190**	St. Louis
Squitieri, Alphonse J	**190**	St. Louis
St. John, Donald R	**102**	Marshall
Staab, Gerald E	**125**	Kansas City
Stacey, Wallace R	**125**	Independence
Stafford, Walter R	**190**	St. Louis
Stahl, Lloyd D	**125**	Overland Park, KS
***Stahly, Randall L**	**042**	Cape Girardeau
Stahr, William D	**042**	Cape Girardeau
Stallard, Donald J	**030**	St. Joseph
Stamatis, John J	**082**	Springfield
Stamps, Gregory S	**082**	Springfield
Standiford, Steven B	**026**	Columbia
Stanley, Brad K	**125**	Independence
Stanley, Charles G	**125**	Kansas City
Stansfield, Julie D	**026**	Columbia
Stark, Karl R	**125**	Kansas City
Stark, William H	**125**	Kansas City
Starke, Keith M	**190**	St. Louis
Starks, Gregory C	**125**	Kansas City
Starr, Steven K	**125**	N. Kansas City
Statland, Harry	**125**	Kansas City
Statland, Morris	**125**	Shawnee Mission, KS
Stauffer, Larry K	**058**	Jefferson City
Stauffer, Robert C	**102**	Joplin
***Steele, Brian K**	**102**	Joplin
Steele, Jack T	**190**	Bridgeton
Steele, Mark T	**002**	Kansas City
Steenbergen, Michael	**058**	Jefferson City
Steffen, Lawrence F	**125**	Shawnee Mission, KS
Steiling, Sylvia A	**190**	St. Louis
Steiman, Barry	**189**	St. Charles
Stein, Bernard	**102**	Joplin
Steinbecker, Keith	**215**	Columbia
Steinberg, Franz U	**190**	St. Louis
Steinberg, John B	**082**	Springfield
***Steinbrecher, Janis M**	**125**	Lee's Summit
Steiner, Alexander J	**190**	St. Louis
Steiner, Marvin P	**125**	Independence
Steinhaus, David M	**125**	Kansas City
Stelmach, Walter J	**125**	Kansas City
Stenberg, Michael D	**050**	Kansas City
Stephen, C. Ronald	**190**	Chesterfield
Stephenson, Hugh E	**026**	Columbia
Stephenson, William T	**125**	Kansas City
Sterkel, Barbara B	**190**	St. Louis
Sterkel, Richard L	**190**	St. Louis
Stevens, Edward M	**030**	St. Joseph
Stevens, Sheridan	**125**	Independence
Stewart, Angela R	**026**	Columbia
Stewart, Harry A	**125**	Shawnee Mission, KS
Stewart, James G	**190**	St. Louis
Stewart, James L	**050**	Weatherby Lake
Stewart, L. Paul	**190**	St. Louis
Stewart, Robert B	**082**	Springfield
Stiaszny, Louis K	**125**	Kansas City
Stickle, Arthur W	**190**	St. Louis
Stickley, Louis P	**190**	St. Louis
Stiene, Henry A	**102**	Joplin
Stiles, Michael C	**125**	Kansas City
Stiles, Michella M	**125**	Kansas City
***Stillie, G. Donald**	**125**	Kansas City
Stillings, Wayne A	**190**	St. Louis

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Stith, John A	190	St. Louis
Stockton, Raymond W	125	Shawnee Mission, KS
Stockwood, Robert C	178	Sedalia
Stoecker, Willeford J	042	Cape Girardeau
Stoecker, William V	135	Rolla
Stohr, Paul E	190	St. Charles
Stokes, Douglas L	030	St. Joseph
Stokes, James M	190	St. Louis
Stoliar, John B	190	St. Louis
Stone, Kenneth D	202	Sikeston
Stoneman, William, III	190	St. Louis
Stoops, Stephen L	125	Kansas City
Stout, Carl N	125	Independence
Stout, Tim	215	Shawnee, KS
Stoy, Robert P	026	Columbia
Stradford, H. Todd	026	Columbia
Strain, Herb A	125	Kansas City
Strasberg, Steven M	190	St. Louis
Stratemeier, Edward H	125	Blue Springs
Straub, David L	102	Joplin
Strauss, Carl F	125	Kansas City
Strecker, William B	190	St. Louis
Stricker, William E	135	Rolla
Strickland, James C	190	St. Louis
Stringer, Kenton L	166	Aurora
***Stringer, Robert F**	102	Joplin
Strobach, Kurt F	190	St. Louis
Stroble, Mark	190	St. Louis
Stromberg, Brent V	190	St. Louis
Stromberg, Eric D	125	Kansas City
Strong, Alexandra J	125	Kansas City
Stronsky, David	190	St. Louis
Stroud, Malcolm H	190	Dallas, TX
Stryker, William I	190	Osprey, FL
Stuart, Byron M	026	Boonville
Stuart, Danl D	046	Brunswick
Stuart, Wallace	190	Paradise Valley
Stuber, Robert R	030	St. Joseph
***Stucka, John, Jr.**	102	Joplin
Stueman, Lawrence G	150	Louisiana
Stufflebam, Robert E	082	Springfield
Stuppy, Mark S	082	Springfield
Stuppy, Robert J	102	Joplin
Sturtevant, Harwood N	082	Springfield
Su, Philo S	058	Jefferson City
Suarez, Alberto	125	Lee's Summit
Suarez-Solar, Pedro L, Jr.	190	St. Louis
Suarez-Solar, Pedro L	189	Chesterfield
Subramanian, S.	102	Carthage
Sudekum, Joseph M	190	St. Louis
Sueper, Robert H	190	St. Louis
Sugarbaker, Everett D	058	Jefferson City
Sugarbaker, Stephen P	058	Jefferson City
Sullivan, Bradley H	125	Kansas City
Sullivan, Christine	125	Overland Park, KS
Sullivan, Clement J	190	St. Louis
Sullivan, Dan T	082	Springfield
Sullivan, David M	082	Springfield
Sullivan, John A	082	Springfield
Sullivan, William W	190	St. Louis
Sultan, Tipu	190	Florissant
Sumer, Emel A	190	Bridgeton
Summerfield, Anita	206	Springfield
Summers, John B	190	St. Louis
Summers, Joseph S	058	Sun City, AZ
Summers, Thomas F	190	Olney, IL
Sun, Belinda	215	Fairway, KS
Sundaresan, Sudhir	002	St. Louis
Sunderji, Shiraz	190	St. Louis
Sundstrom, Frank D	082	Springfield
Sundt, Thoralf M	002	St. Louis
Sunshine, Herbert	190	St. Louis
Suseela, Dasari	125	Kansas City
Susi, Jesse G	190	St. Louis
Sutherland, Charles J	190	St. Louis
***Suthoff, Jim**	102	Joplin
Sutphen, Eric J	190	St. Louis
Sutter, Richard A	190	St. Louis
Sutton, Matthew B	215	Kansas City
Sutton, Trevor S	002	St. Louis
Suwannasri, Rudee	190	St. Louis
Svancarek, William P	190	St. Louis
Swaim, Truett	125	Blue Springs
Swan, Kia L	215	Florissant
Swaney, Charles M	026	Columbia
Swango, John S	082	Springfield
Swank, Darrell	102	Joplin
Swanson, Robert G	215	Ballwin
Swaykus, Bernard T	190	Bridgeton
Sweeney, Michael J	125	Kansas City
Sweeney, Thomas P	082	Springfield
Sweiger, James H	054	Plattsburg
Swinfard, Ronald W	026	Columbia
Switzner, Diane L	082	Springfield
Sylvanovich, W. Richard	190	St. Louis
Szabados, Ernest D	125	Independence
Szewczyk, Michael J	026	Columbia
Szoko, Edward	190	St. Louis
Szymanski, Stanley R	078	Macon

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Taege, Alan J	030	St. Joseph
Tailor, Chandrakant C	190	St. Louis
Takacs, Robert J	125	Kansas City
Talbert, Clifford R	042	Cape Girardeau
Tamblyn, Claire L	125	Tubac, AZ
Tang, Teodoro	135	Salem
Tanner, Christina E	082	Springfield
Tanner, John P	125	Kansas City
Tanner, Robert H	058	Jefferson City
***Tanner, Scott W**	058	Jefferson City
Tanphaichitr, Kongsak	190	St. Louis
Tansuwan, Chukiat	190	St. Louis
Taormina, Marc K	125	Independence
Tariq, Manzoor A	190	Chesterfield
Tate, Kara L	125	Kansas City
Tatini, Paparao	002	St. Louis
Taute, Hermann	190	St. Louis
Taylor, Eugene D	190	St. Louis
Taylor, Joseph A	215	Columbia
Taylor, Leon A	058	Jefferson City
Taylor, Philip W	042	Cape Girardeau
Taylor, Steve J	014	Mexico
Taylor, William K	082	Springfield
Teague, J. Lynn	026	Columbia
Teff, Richard J	215	Columbia
Tegeler, Kent E	050	Liberty
Tegtmeyer, Chris	115	Lebanon
Tekwani, Hiralal T	190	St. Louis
Tellerman, Barbara J	026	Columbia
Templer, Jerry W	026	Columbia
Tendai, Mark M	082	Springfield
Tenorio, Arturo A	158	Stanberry
Tenorio, Genoveva	158	Albany
Tepper, Arnold	190	St. Louis
Ternberg, Jessie L	190	St. Louis
Terry, Boyd E	026	Columbia
Terry, James F	082	Springfield
Terry, James W	042	Cape Girardeau
Terry, Martha S	215	Columbia
Tess, Allen F	190	Florissant
Tessier, John E	190	St. Louis
***Tewis, Huey D**	042	Cape Girardeau
Thaker, Jayesh	215	Kansas City
Thal, Sanford M	190	St. Louis
Thalblum, Harvey	125	Kansas City
Thale, Thomas R	190	Ballwin
Thawley, Stanley E	190	St. Louis

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Theby, Janet E	058	Eldon
Thedinger, Bradley S	125	Kansas City
Theel, Otto W, Jr.	125	Shawnee Mission, KS
Thesing, John A	125	Lenexa, KS
Thibeault, Donald W	125	Kansas City
Thiel, J. Allen	190	St. Louis
Thiele, Belmont R	190	Las Vegas, NV
Thiele, Otto K	189	St. Charles
Thierauf, Charles G	190	St. Louis
Thies, Jerome H	214	Osceola
Thoma, George E, Jr.	190	St. Louis
Thomas, Alexis G	125	Kansas City
Thomas, Christopher Y	125	Shawnee Mission, KS
Thomas, Deborah G	042	Cape Girardeau
Thomas, F. Anthony	050	Kansas City
Thomas, Horace E	026	Columbia
Thomas, J. Regan	190	St. Louis
Thomas, James J	125	Kansas City
Thomas, Jonathan L	042	Cape Girardeau
Thomas, Leslie D	050	N. Kansas City
Thomas, Matthew A	190	St. Louis
*Thomas, Norvin E	014	Mexico
Thomas, Robert M	026	Columbia
Thomasson, David D	082	Springfield
Thomasson, Jeffrey L	190	St. Louis
Thomasson, Mary W	190	St. Louis
Thompson, David E	125	Kansas City
Thompson, F Gregg	030	St. Joseph
Thompson, Frederick E	050	Liberty
Thompson, Frederick L	214	Nevada
Thompson, James E	082	West Plains
Thompson, M. Bryant	190	Chesterfield
Thompson, Paul H	208	Branson
Thompson, Paul D	042	Cape Girardeau
Thompson, Robert W	190	St. Louis
Thompson, Robert F	125	Kansas City
Thompson, Scott W	125	Kansas City
Thomure, Michael F	002	St. Louis
Thornton, F. Parker, III	125	Overland Park, KS
Thornton, Fred H	202	Sikeston
Thornton, Michael K	174	Ste. Genevieve
Thorpe, William P	042	Cape Girardeau
Threlkeld, Kevin L	002	Lake St. Louis
Throne, Ben J	125	Kansas City
Thurmann, Manfred	190	Chesterfield
Tice, Wayne K	125	Lee's Summit
Tichenor, Robert W	190	Fenton
Tiefenbrunn, Sharon F	190	St. Louis
Tiemann, James H	215	Lee's Summit
Tietjen, Fred O	120	Osage Beach
Till, Bennie N	034	Poplar Bluff
Tillema, David A	125	Kansas City
Tillman, Mary A	190	St. Louis
Tilson-Mallett, Nancy R	125	Kansas City
Tilzer, Seth	190	Florissant
Tindall, Robert N	190	Spirit Lake, IA
Tinger, Alfred	215	Ellisville
Tinsley, John C	026	Columbia
Tiojanco, Milagros E	125	Kansas City
Tippett, Jack C	190	St. Louis
*Tipton, Richard J	042	Cape Girardeau
Titterington, Frank W	125	Kansas City
Tobey, Albro C, Jr.	190	St. Louis
Tobin, Gregory A	042	Cape Girardeau
Tobin, Marla J	118	Higginsville
Tobin, Robert F	030	St. Joseph
Tobler, Jerry	190	St. Louis
Tobler, Randall W	190	St. Louis
Tolan, Robert W, Jr.	190	St. Louis
Tomlinson, David L	125	Kansas City
Tompson, Robert V	046	Moberly
Torontow, R. John	214	Nevada
Torrence, Ralph J	190	Chesterfield
Totty, William G	190	St. Louis
Toubes, Daniel B	125	Kansas City
Towle, Dana R	050	Kansas City
Towle, Daniel J	125	Kansas City
Trachtenberg, Jeffrey D	215	St. Louis
Trammell, Lee W	026	Columbia
Traxel, William L	034	Poplar Bluff
Treacy, Bryan J	066	Bolivar
Treadwell, Randall E	190	Chesterfield
Trecha, Randal R	026	Columbia
Trentham, Orin P, III	102	Joplin
Trevor, Richard P	125	Kansas City
Triantafillou, Anastasios	190	St. Louis
Trimble, George X	125	Kansas City
Trimmer, Jeanne M	190	St. Louis
Trinidad, Hermanito R	078	Chillicothe
Triplett, Daniel A	050	Liberty
Triska, Roland A	190	St. Louis
Troeh, Melvin R	125	Independence
Troop, Bryan R	190	St. Louis
Trotta, Philip C	190	St. Louis
Trotter, Francis O, Jr.	190	Carrollton
Trotter, W. Yates	082	Springfield
Troug, William E	125	Kansas City
Trowbridge, Ellsworth	125	Sun City, AZ
True, James D	050	Kansas City
True, John H	034	Poplar Bluff
Trueblood, Alva C	190	St. Louis
Trueblood, Michael C	042	Cape Girardeau
Trugly, Edith S	190	St. Louis
Trumbower, William D	026	Columbia
Trygg, Kelly A	066	Bolivar
Tsang, John L	082	Honolulu, HI
Tschudin, Garland	190	St. Louis
Tsifutis, Argyrios A	190	St. Louis
Tucker, Dolores R	190	Chesterfield
Tucker, George L	190	Chesterfield
Tucker, Leslie E	074	Washington
Tucker, Robert E	190	St. Louis
Tungsiripat, Soros	070	Kennett
Tuohy, Gerald F	125	Kansas City
Tupper, Joel	102	Joplin
Turano, William L	125	Raytown
Turfboer, Robert	102	Greenville, NC
Turgeon, Ronald P	190	St. Louis
Turnbaugh, Thomas R	058	Jefferson City
Turner, Glenn O	082	Springfield
Turner, James D	074	Washington
Turner, Kirby L	034	Poplar Bluff
Turner, Michael L	034	Poplar Bluff
*Turner, Timothy T	002	Barrington, IL
Turner, William A	214	Nevada
*Turpin, F. Duane	190	Bridgeton
Tutera, Dominic F	125	Kansas City
Tuttle, Jay F	138	Creve Coeur
Tyler, Thomas D	118	Richmond

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Uchiyama, Robert C	190	Chesterfield
Uhlemann, John H	189	St. Charles
Uhlemeyer, Henry A	190	St. Louis
Uhrig, Jack R	198	Marshall
Uketui, Ozoemenam I	030	St. Joseph
Umar, Ibrahim S	189	St. Peters
Underwood, Dick H	125	Leawood, KS
Underwood, Johnson, III	050	N. Kansas City
Ungvari, Joseph C	190	St. Louis
Unwin, Donald R	002	St. Louis
*Upton, Gary L	026	Columbia

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Vacca, Joseph B	190	St. Louis
Vajaranant, Manit	118	Lexington
Valach, Frank J	190	St. Louis
*Vale, Janett A	125	Kansas City

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Vale, Janie R	Columbia	**026**
Valera, Salvador S	St. Joseph	**030**
Vallurupalli, Vijayalakshmi	Bridgeton	**190**
Valtierra, Cesar A	Ballwin	**190**
Valuck, Richard P, Jr.	Hannibal	**150**
Van Amburg, Albert L, III	Chesterfield	**190**
Van Biber, James T	Independence	**125**
Van Buren, Wilbur D	Kansas City	**002**
Van Buskirk, William C	Shawnee Mission, KS	**125**
Vandewalker, Mark L	Columbia	**026**
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Van Zanten, Niko A	Osceola	**214**
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Varma, Devendra K	Poplar Bluff	**034**
Vas, Wenzel G	St. Louis	**190**
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Vazquez, Jose L	Florissant	**002**
Veitch, John M	Joplin	**102**
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Vilmer, Stephen E	N. Kansas City	**050**
Viloria, Alberto B	St. Louis	**190**
Vinyard, Jack L	Joplin	**102**
Viril, Leonardo C	Kansas City	**125**
***Visconti, John L**	St. Louis	**215**
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Vogel, Curt M	Columbia	**026**
***Vogelsang, Judith K**	Kansas City	**125**
Vollmer, Dennis G	San Antonio, TX	**190**
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Voth, Harold W	Shawnee Mission, KS	**125**
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Wachter, Ronald M	Springfield	**082**
Waddell, Kenneth E	Pleasant Hope	**082**
Wade, Kim C	Kansas City	**125**
Wade, Scott A	St. Joseph	**030**
Wadley, John J	Sedalia	**178**
Wadlow, Ernest E	Phoenix, AZ	**030**
Wagan, Primitiva C	St. Louis	**190**
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Waggoner, Sharon E	St. Joseph	**030**
Wagner, Daniel G	Chesterfield	**002**
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Waheed, Shahid	Mexico	**014**
Wakefield, Mark R	Columbia	**215**
Wakeman, Newt, Jr	Springfield	**082**
Wald, Stanley M	St. Louis	**190**
Walden, David T	St. Louis	**002**
Walden, James M	Kansas City	**125**
Waldschmidt, Mike L	Liberty	**125**
Walentik, Corinne	St. Louis	**190**
Walker, Ambrose T	Springfield	**206**
Walker, Andrew	Leawood, KS	**002**
Walker, Francis S	St. Louis	**190**
Walker, Gary K	Springfield	**082**
Walker, Gregory E	Independence	**125**
Walker, Harvey, Jr.	St. Louis	**190**
Walker, Howard S	St. Louis	**190**
Walker, J Leslie	St. Louis	**190**
Walker, Orville C	Independence	**125**
Walker, William M	Rogersville	**082**
Wall, Harry C	Shawnee Mission, KS	**125**
Wall, Joe A	Houston	**206**
Wall, Leonard A	Kansas City	**125**
Wall, Norman R	Springfield	**082**
Wallace, Darryl L	Kansas City	**125**
Walley, Lynn J	Hannibal	**150**
Walline, T. Andrew	Kansas City	**125**
Walls, Joseph T	Columbia	**026**
Walls, Kelvin	Independence	**125**
Walsh, Barbara A	St. Louis	**190**
Walsh, James W	St. Louis	**190**
Walsh, Richard J	St. Joseph	**030**
Walters, Frederick P	St. Louis	**190**
Walton, Patrick J	Kansas City	**125**
Waltz, James R	Liberty	**050**
Walz, Bruce J	St. Louis	**190**
Wan, Shaw P	Rolla	**135**
Wankum, Robert P	Jefferson City	**058**
Wantuck, Donald K	Springfield	**082**
Ward, Joe W	Lexington	**118**
Ward, Mark R	Springfield	**082**
Wardell, M. Annette	Springfield	**082**
Waring, J. Michael	Kansas City	**125**
Warren, Ronda Lynn	Kansas City, KS	**215**
Wasserman, Gary M	St. Louis	**190**
***Wasserman, Gary S**	Kansas City	**125**
Wasserman, Mark S	St. Louis	**190**
Waters, Hugh R	Chesterfield	**190**
Wathanacharoen, Suchint	Kansas City	**125**
Watkins, George L	Rancho Santa Fe, CA	**138**
Watson, Richard A	St. Joseph	**030**
Watson, Timothy B	Columbia	**026**
Watson, Tom F	Springfield	**082**
Watson, Trevor F	Columbia	**026**
Watts, Byron E	Jefferson City	**058**
Watts, Samuel M	Mt. Vernon	**166**
Wax, Martin B	St. Louis	**190**
Waxelman, Roger J	Ballwin	**190**
Waxman, Jane Z	Lenexa, KS	**125**
Waxman, Joel E	Springfield	**082**
Wayne, Sherwyn J	St. Louis	**190**
***Weaver, Bruce E**	Columbia	**026**

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Weaver, Michael L	**125**	Kansas City
Weaver-Osterholtz, Dana J	**026**	Columbia
***Webb, James J**	**102**	Joplin
Webb, John M	**050**	Kansas City
Webb, Karen B	**190**	St. Louis
Webb, Paul B, Jr.	**190**	St. Louis
Weber-Bornstein, Nancy	**042**	Cape Girardeau
Weed, Daniel D	**125**	Kansas City
Weeks, Paul M	**190**	St. Louis
Weide, Allan R	**050**	N. Kansas City
Weiford, Edward C	**125**	Shawnee Mission, KS
Weigand, Robert T	**030**	St. Joseph
Weiler, Thomas J	**190**	St. Louis
Weinand, Ernest E	**030**	Tucson, AZ
Weinberger, Phillip C	**178**	Sedalia
Weinstein, Charles L	**125**	Kansas City
Weinstein, David L	**190**	St. Louis
Weinstein, Stephen H	**026**	Columbia
Weinstock, Leonard B	**190**	St. Louis
Weir, Robert K	**125**	Kansas City
Weir, Royal A	**190**	Ballwin
Weis, Ronald R	**125**	Kansas City
Weise, Marc W	**190**	St. Louis
Weiss, Alan N	**190**	St. Louis
Weiss, Howard	**190**	St. Louis
Weiss, James M	**026**	Columbia
Weiss, James J	**058**	Jefferson City
Weiss, Peter D	**190**	St. Louis
***Weiss, Randy B**	**102**	Joplin
Weiss, Stuart	**190**	St. Louis
Weldon, Virginia V	**190**	St. Louis
Wells, Donald E	**125**	Jacksonville, FL
Wells, Samuel A, Jr.	**190**	St. Louis
Welsh, Laurence C	**190**	St. Louis
Welsh, Thomas E, III	**014**	Mexico
Weltmer, John B, Jr.	**190**	St. Louis
Welton, Stephen T	**202**	Sikeston
Wempe, George R	**158**	Rio Verde, AZ
Wempe, Michael J	**030**	St. Joseph
Wenneker, Alvin S	**190**	St. Louis
Wenner, Herbert A	**125**	Merriam, KS
Werner, Dean F	**050**	Kansas City
Werner, F. Scott	**050**	N. Kansas City
Werner, William A	**190**	St. Louis
Werth, Joseph A	**058**	Jefferson City
***Wescott, Thomas P**	**110**	Holden
West, Harold D	**125**	Independence
West, Joseph W	**190**	Kirkwood
Westcott, Bruce R	**042**	Jackson
Westerfeld, Roy A	**189**	St. Charles
Westerman, Robert N	**190**	St. Louis
Westfall, Scott G	**190**	Chesterfield
Westfall, Susan H	**190**	Chesterfield
Westgate, Steven J	**026**	Columbia
Westhoff, David D	**058**	Jefferson City
Weston, Kenneth G	**026**	Columbia
Westrich, David J	**042**	Cape Girardeau
Wethers, Darren E	**002**	St. Louis
Wetzel, C. Robert	**086**	Clinton
Wetzel, Gus S	**086**	Clinton
Wexler, Stephen A	**190**	St. Louis
Weyerich, Noel F	**190**	St. Louis
Weyman, Philip J	**190**	Chesterfield
Wheeler, Charles B	**125**	Kansas City
Wheeler, Eden	**125**	Independence
Wheeler, Paul D	**050**	Liberty
Wheeler, Robert L	**214**	Harrisonville
Whitacre, Marc M	**125**	Prairie Village, KS
Whitaker, James H	**125**	Kansas City
White, Charles H	**125**	Shawnee Mission, KS
White, Eugene F	**135**	Rolla
White, Newton B	**190**	St. Louis
White, William L	**125**	Kansas City
Whitener, Miles C	**190**	St. Louis
Whiteside, Leo A	**190**	St. Louis
Whiting, Richard B	**190**	St. Louis
Whitlock, C. Courtney	**082**	Springfield
Whitman, Daniel S	**125**	Kansas City
Whitmore, J. Stewart	**125**	Washington, NC
Whittaker, Thomas J	**125**	Kansas City
Whitten, J. Stephen	**042**	Cape Girardeau
Whitten, M. Foster	**102**	Carthage
Whittico, James M	**190**	St. Louis
Wiant, James R	**190**	St. Louis
Wible, Jerry C	**082**	Springfield
Wice, Martin B	**190**	St. Louis
Wicklund, Brian M	**125**	Kansas City
Wiegand, Herbert C	**190**	St. Louis
Wiele, Kimberly N	**190**	St. Louis
Wilbois, Ronald P	**190**	St. Louis
Wilcox, Dennis M	**125**	Leawood, KS
Wild, Alan P. K.	**190**	Chesterfield
Wiles, Stephen B	**125**	Kansas City
Wilhelm, Warren F	**125**	Lake Ozark
Wilhite, Tria K	**150**	Shelbyville
Wilkins, Michael S	**125**	Kansas City
Wilkinson, David	**190**	St. Louis
Wilkinson, Everett A	**125**	Prairie Village, KS
Wilkinson, Linda	**125**	Kansas City
Willcoxon, Robert L	**102**	Joplin
Williams, C. Mark	**125**	Kansas City
Williams, Carol F	**190**	St. Louis
Williams, Craig W	**042**	Cape Girardeau
Williams, Fred	**026**	Columbia
Williams, John W, IV	**082**	Springfield
Williams, Joseph C	**125**	Shawnee Mission, KS
Williams, Joseph	**190**	St. Louis
Williams, Paul A	**125**	Kansas City
Williams, Paul A	**002**	St. Louis
Williams, R. Jerome, Sr.	**190**	St. Louis
Williams, R. Jerome, Jr.	**190**	St. Louis
***Williams, Robert J**	**030**	St. Joseph
Williams, Starks J	**125**	Kansas City, KS
Williams, Todd L	**102**	Joplin
Williamson, Blake J	**125**	Overland Park, KS
Williamson, George L	**050**	Phoenix, AZ
Williamson, Harold A	**026**	Columbia
Williamson, Paul S	**002**	Kansas City
Willman, Charles R	**030**	Springfield
Willman, Martin L	**189**	St. Charles
Willman, Vallee L	**190**	St. Louis
Willoughby, Jean B	**125**	Kansas City
Wills, Theodore E	**026**	Columbia
Willumsen, Henry C	**030**	St. Joseph
Wilson, Charles F	**042**	Cape Girardeau
Wilson, David E	**050**	Smithville
Wilson, Elizabeth	**215**	Columbia
Wilson, George P	**026**	Columbia
Wilson, J. Mark	**082**	Springfield
***Wilson, James W**	**082**	Springfield
Wilson, Roy E	**082**	Springfield
Wilson, Timothy A	**050**	Kansas City
***Wilson, W. Timothy**	**082**	Springfield
Wilson, William T	**125**	Independence
Wilt, David A	**125**	Kansas City
Wilucki, Melvin R	**190**	St. Louis
Wimmer, Warren J	**190**	Florissant
Windmiller, M. Eugene	**026**	Columbia
Winer, Herbert J	**125**	Kansas City
Winer, Nathaniel	**125**	Kansas City
Winkelmann, Mary K	**215**	Kansas City, KS
Winkelmeyer, William K	**026**	Columbia
Winkler, Terry	**082**	Springfield
Winn, George W	**026**	Boonville
Winnacker, John L	**026**	Columbia
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Winter, Tyrus D	**190**	St. Louis

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Wise, George W Shawnee Mission, KS	125
Wise, Morris F Kansas City	125
Wissner, Seth E St. Louis	190
Withrow, Donald St. Louis	190
Withrow, John B Kansas City	050
Witten, David M Columbia	026
Wittgen, Edward M St. Louis	190
Wittmer, Marc R Springfield	082
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Wolaniuk, Anna C St. Charles	190
Wolf, Jack W Kansas City	125
Wolf, Marion L Springfield	082
Wolf, Mitchel L St. Louis	190
Wolfe, Edward M St. Louis	190
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Won, Russell St. Louis	190
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Wong, George F, III Springfield	082
Wood, John A Chesterfield	190
Wood, Thomas O Poplar Bluff	034
***Woods, Brenda L** Jefferson City	058
Woods, John J, Jr. St. Louis	190
Woodson, Mark E St. Louis	190
***Woodward, Owen L** Atlanta	046
Woodward, William W Holiday Island, AR	125
Woody, Mary Therese Kansas City	215
Wool, Gerald St. Louis	190
Wooldridge, David Kansas City	215
Wooldridge, Wilfred E Springfield	082
Woolery, William G Sedalia	178
Woolsey, Joyce E St. Louis	190
Wooten, Michael B Springfield	082
Workman, Charles E Mission, KS	050
Workman, George M Hermann	074
Wortmann, Robert F Hilton Head Isl, SC	125
Wotawa, William J St. Louis	190
Wright, Andy J Springfield	082
***Wright, James C** Perryville	174
Wright, Jeffrey M St. Louis	190
***Wright, Michael D** St. Joseph	030
Wright, R P Pittsburg, PA	125
Wright, Rick W St. Louis	190
Wright, Robert W, III Kansas City	125
***Wright, Robert A** St. Louis	190
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Wu, William Q Prairie Village, KS	125
Wuellner, David H Sedalia	178
Wulfers, Michael C Cape Girardeau	042
Wulff, George J Miami, FL	190
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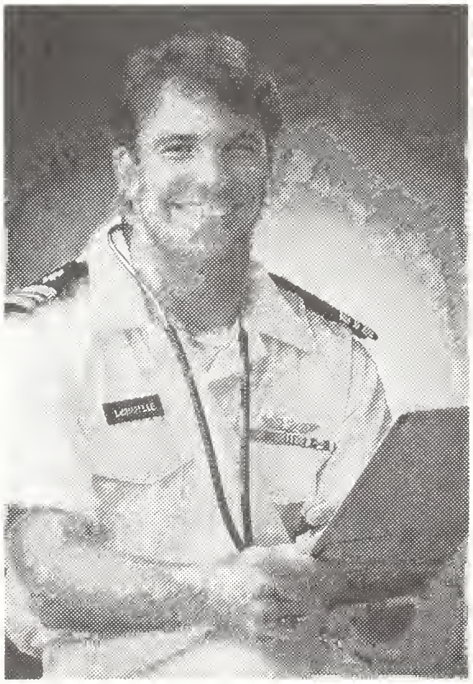

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Yates, Karen Cape Girardeau	**042**
Yates, William D St. Louis	**190**
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Yeast, John D Kansas City	**125**
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***Yocum, Russell S** Platte City	**125**
Yoon, Jin S Chillicothe	**078**
Yoon, Kong-Woo St. Louis	**190**
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Youmans, David C Ballwin	**215**
Youmans, Ronald A Prairie Village, KS	**125**
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Young, Robert A Chesterfield	**190**
Young, Thomas J St. Joseph	**030**
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Younger, Anita C Overland Park, KS	**190**
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Zacharias, Kulangara P Columbia	**026**
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Zahn, Robert L Springfield	**082**
Zamah, Nezaam M Kansas City	**125**
Zanol, John M Columbia	**026**
Zanol, Karen E Columbia	**026**
Zarr, James S Kansas City	**125**
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Ziemianski, Matthew C Kansas City	**125**
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***Zipper, Ronald** N Kansas City	**050**
Zitsch, Robert P, III Columbia	**026**
Zivnuska, Frederick R St. Louis	**190**
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Zukaitis, Mark G Kansas City	**125**
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Zurowski, Susan M Columbia	**026**
Zylka, J. Michael St. Louis	**190**
Zukaitis, Mark G Blue Springs	**125**

Primary Specialty Codes

A	Allergy
AI	Allergy & Immunology
AN	Anesthesiology
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
CHN	Child Neurology
CHP	Child Psychiatry
CLP	Clinical Pathology
CRS	Colon & Rectal Surgery
CCM	Critical Care Medicine
D	Dermatology
DR	Diagnostic
EM	Emergency Medicine
END	Endocrinology
FPS	Facial Plastic Surgery
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GS	General Surgery
GYN	Gynecology
HEM	Hematology
HNS	Head & Neck Surgery
ID	Infectious Diseases
IM	Internal Medicine
MFM	Maternal & Fetal Medicine
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NS	Neurological Surgery
NM	Nuclear Medicine
NR	Nuclear Radiology
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OS	Other
OTO	Otolaryngology
PTH	Pathology
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PDR	Pediatric Radiology
PDS	Pediatric Surgery
PM	Physical & Rehabilitation Medicine
PS	Plastic Surgery
P	Psychiatry
PH	Public Health
PUD	Pulmonary Disease
RO	Radiation Oncology
TR	Radiation Therapy
R	Radiology
REN	Reproductive Endocrinology
RHU	Rheumatology
TS	Thoracic Surgery
U	Urology
VS	Vacular Surgery

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*Doctor of Osteopathy

Membership Roster by Primary Specialties

Allergy (A)

Caldwell, Joseph L	082	Springfield
Critchlow, Michael E	042	Cape Girardeau
Loren, Michael L	125	Independence
McMorrow, Nora K	190	Crestwood
Miles, Wayne B	082	Springfield
Nguyen, Helen T	030	St. Joseph
***Sacha, Robert F**	042	Cape Girardeau
Stricker, William E	135	Rolla
Thiel, J. Allen	190	St. Louis
Vandewalker, Mark L	026	Columbia

Allergy & Immunology (AI)

Berson, Douglas R	002	Chesterfield
Bolinske, Robert E	190	St. Louis
Chapman, Jean A	042	Cape Girardeau
Dankner, Arnold	190	Chesterfield
Dankner, Rand E	190	Chesterfield
Korenblat, Phillip E	190	St. Louis
Lux, Gregory K	082	Springfield
Onder, Robert F	190	St. Louis
Straub, David L	102	Joplin

Anesthesiology (AN)

Abada, Rolando	190	St. Louis
Adams, Riley R	042	Cape Girardeau
Almuttar, Wasif F	158	Maryville
Arnold, Donald E	190	St. Louis
Axness, Mark E	082	Springfield
Bagby, Jack M, Jr	082	Springfield
Bailiff, Robert	082	Springfield
Bashyakarla, Rajeeva K	102	Joplin
Batan-Co, Ruby L	190	Chesterfield
Baudendistel, Lawrence J	190	St. Louis
Behbahani, Parviz M	190	Bridgeton
Bell, Stephen	190	St. Louis
Bernard, Lisa	125	Kansas City
Bessonny, Eric J	190	St. Louis
Binda, Robert E	125	Kansas City
Bluestone, Kenneth I	125	Leawood, KS
Blum, Carol A	002	Excelsior Springs
Blum, Philip C	125	Kansas City
Bode, Eugene T	125	Kansas City
Borup, Jerrell L	082	Springfield
Bowenschulte, Bradley A	082	Springfield
Bowser, Robert L	050	Independence
Bredemann, Jeffrey A	125	Kansas City
Brian, William J	082	Springfield
Brigden, Robert B	102	Neosho
Brown, Freeman F, III	190	Ballwin
Brown, Michael S	150	Hannibal
Brown, Norbert W	125	Kansas City
Bucol, Kevin D	190	St. Louis
Bult, Mark J	082	Springfield
Butterfield, Mari Anne	125	Lee's Summit
Casement, Brian A	125	Kansas City
Chang, Chil K	026	Columbia
Charapata, Steven G	125	Kansas City
Chien, David W	190	St. Louis
Cobb, Milton L	190	St. Louis
Cohen, Harry B	014	Mexico
Cohn, Steven G	125	Kansas City
Cole, Donald E	066	Springfield
Coleman, Kevin A	190	St. Louis
Cook, James R	082	Springfield
***Corzine, John J**	030	St. Joseph
Couper, Nicholas B	026	Columbia
Criscione, James S	190	St. Louis
Crumpacker, Rex K	102	Joplin
Cunningham, Milamari A	026	Columbia
Daily, James M	082	Springfield
Danner, Shavonne L	125	Leawood, KS
***Davis, Larry E**	050	N. Kansas City
***Delaney, Adrain J, Jr.**	125	Kansas City
***DeLucia, Joseph A**	206	West Plains
Doerhoff, Adelia L	058	Jefferson City
Dolan, Patrick H	190	St. Louis
Duckett, William D	135	Rolla
Edelman, Kent J	102	Joplin
Eggers, George W, Jr.	026	Columbia
Ellis, Ronald L	082	Springfield
Ellis, Stephen C	125	Independence
Esther, John W	082	Springfield
Evenson, Curtis C	082	Springfield
Faszholz, Mark S	190	Chesterfield
Ferrari, Herbert A	190	St. Louis
Fibuch, Eugene E	125	Kansas City
***Fisher, Robert B**	026	Columbia
Flores, Jhonson E	190	St. Louis
Fogel, Steven T	190	Chesterfield
Foote, Daniel D	082	Springfield
Forand, Joseph M	190	St. Louis
***Frederick, Mark R**	058	Jefferson City
Friedman, Michael J	026	Columbia
Friedrich, Anthony P	190	St. Charles
Friend, T. Gregory	125	Kansas City
Fromme, Glenn A	082	Springfield
Fryer, Dorothy S	190	St. Louis
Gahn, Richard S	002	St. Louis
Gibbons, James J	190	St. Louis
***Gibbons, Jerry L**	190	St. Louis
Gibbons, Robert T, Jr.	125	Overland Park, KS
Gibson, William P	190	Chesterfield
Gilliland, Craig	002	Kansas City
Glenski, James A	125	Kansas City
Gordon, Bruce J	026	Columbia
***Greer, Sam T**	102	Joplin
Griffin, Donald R	002	Kansas City
Gunderson, Jeffrey K	082	Springfield
Gupta, Nilakshi	026	Columbia
Gurba, Carol L	125	Kansas City
Guy, Cynthia S	190	St. Louis
Hagen, Douglas W	125	Kansas City
Hari, Magaral S	102	Joplin
Hata, Tara M	026	Columbia
Heise, Julie R	125	Liberty
Herdoiza, Alfonso W	125	Shawnee Mission, KS
Hervey, William H	125	Kansas City
Hinds, R. David	026	Columbia
Hoech, George P, Jr.	125	Kansas City
Hoehner, Paul J	030	St. Joseph
Holloway, Robert B	190	St. Louis
Holtmann, Barbel	190	St. Louis
Hubbard, John D	125	Kansas City
Hudson, Randall B	125	Kansas City
Huff, Kalaichelvi R	102	Joplin
***Hull, Jeffrey F**	125	Kansas City
Hull, Timothy A	125	Kansas City
Iwane, Akira	190	Chesterfield
Jaax, Jeffrey D	125	Kansas City
Janeczko, Gregory F	082	Springfield
Jenkins, James J	190	St. Louis
Johnson, Garry A	190	Des Peres
Jones, Dwayne E	125	Kansas City
Jones, Gale O	125	Kansas City
Jones, Robin R	026	Columbia
Jorgensen, Eric D	026	Columbia
Joshi, Surekha K	190	St. Louis
Kappesser, Roland C	190	St. Louis

Specialty Roster (as of 7/29/96)

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*Doctor of Osteopathy

Keller, Barbara P	026	Columbia
Kelly, James B	125	Kansas City
Kelly, Joseph G	050	N. Kansas City
Kenney, John D, III	125	Overland Park, KS
***Kesseler, Randall G**	082	Springfield
Khoury, Cecile S	125	Leawood, KS
Kim, William W	190	St. Louis
Kimble, Harvey S	125	Kansas City
King, James A	002	Des Peres
Kiyanclar, M. Emin	190	St. Louis
Kohm, Mary Jane F	002	St. Louis
Krug, Paul E	125	Kansas City
Kulkarni, Nandini S	190	St. Louis
Kussman, Mary E	002	St. Louis
Lampert, Benjamin A	082	Springfield
Landrum, Alice L	026	Columbia
Laposky, Lynda L	190	Chesterfield
Latour, Jonathan G	026	Columbia
Laughlin, Thomas P	125	Kansas City
Lawson, Noel W	026	Columbia
Lee, Leander K	190	St. Louis
Lerner, Bruce	125	Independence
Lobdell, Creig M	082	Springfield
***Logston, David G**	082	Springfield
Lonergan, James H	125	Kansas City
***Lucio, John C**	058	Jefferson City
Ludwikosky, Mikel A	125	Lee's Summit
Lytle, Michael F	125	Shawnee Mission, KS
Macler, Henry H, Jr.	190	Augusta
Maddipati, Sreedevi	190	St. Louis
Mallow, James E	125	Kansas City
Matson, Jeffrey A	125	Kansas City
Matthews, J. Mark	125	Kansas City
Mayer, Lawrence M	042	Cape Girardeau
Mayuga, Edgardo G	190	St. Louis
McCord, E. Scott	026	Columbia
McCray, Stephen A	050	N. Kansas City
McDonald, Michael G	102	Joplin
McIntosh, Donald E	125	Kansas City
McNitt, Jay D	125	Kansas City
Meridy, Howard W	102	Joplin
Mestad, Peter H	125	Kansas City
Meyer, D. Joseph , Jr.	026	Columbia
***Michael, Roy A**	058	Jefferson City
Miller, Robert N	190	St. Louis
Moore, Richard E	042	Cape Girardeau
***Morley, Ronald F**	058	Jefferson City
Nelson, Richard E	125	Kansas City
Neu, Stephen J	082	Springfield
Nielsen, Carl H	190	St. Louis
Nordhues, Craig A	082	Springfield
Oakley, Margaret M	190	St. Louis
Opper, Susan E	125	Kansas City
Orr, Robert M	125	Kansas City
Owens, William D	190	St. Louis
Parker, Craig A	125	Kansas City
Parker, Kim E	125	Kansas City
Parks, Jon C	034	Poplar Bluff
Patel, Bipin T	030	St. Joseph
Pavelonis, Joel D	002	Kansas City
Perryman, Kathy M	125	Kansas City
Petersen, Larry D	082	Springfield
Piontek, James F	050	Liberty
Politi, Gregory B	125	Kansas City
Porter, Michael J	125	Kansas City
Porter, Susan S	125	Kansas City
Potts, Fred E, III	082	Strafford
Powers, Catherine A	125	Leawood, KS
Presutto-Nelson, Kathleen A	082	Springfield
Pryor, Ira Joe	102	Joplin
Rao, Vijaya Kumar P	102	Joplin
***Ray, Terry L**	026	Columbia
Reaney, John A	125	Kansas City
***Rhoads, Mark D**	102	Joplin
***Ripperger, Kevin L**	082	Springfield
Roa, Necita L	002	St. Louis
Robertson, Terence A	125	Kansas City
Rodrigo, Bernardo R	190	St. Louis
Romkema, George E	190	St. Louis
Roth, Alfred D	125	Mission, KS
Rumpf, Ronald P	026	Columbia
***Russell, Robert B**	042	Cape Girardeau
Schane, Catherine L	082	Springfield
Schneider, J. Michael	082	Springfield
Schnurr, Thomas C	058	Jefferson City
Schuessler, Edward C	190	St. Albans
Shelley, William C	125	Kansas City
***Shipman, Wade M**	082	Rogersville
Shopper, Glenn K	125	Kansas City
Slimack, Joseph P	002	Chesterfield
Smith, Sally L	190	Chesterfield
***Smith, Toni R**	148	Kirksville
Smith, Victorija L	190	Ballwin
Southwick, Christopher L	026	Columbia
Spade, Diana J	082	Springfield
Stark, William H	125	Kansas City
***Steele, Brian K**	102	Joplin
Stewart, Angela R	026	Columbia
Stiles, Michella M	125	Kansas City
Stoops, Stephen L	125	Kansas City
Stromberg, Eric D	125	Kansas City
***Suthoff, Jim**	102	Joplin
Sutton, Trevor S	002	St. Louis
***Tanner, Scott W**	058	Jefferson City
Tate, Kara L	125	Kansas City
Tatini, Paparao	002	St. Louis
***Tewis, Huey D**	042	Cape Girardeau
Thomas, James J	125	Kansas City
Thompson, David E	125	Kansas City
Thompson, Paul H	208	Branson
Tiojanco, Milagros E	125	Kansas City
Tomlinson, David L	125	Kansas City
Towle, Daniel J	125	Kansas City
Triantafillou, Anastasios	190	St. Louis
Tuohy, Gerald F	125	Kansas City
Vallurupalli, Vijayalakshmi	190	Bridgeton
Venneman, Charles R	125	Kansas City
***Vialle, Gene M**	125	Kansas City
Vogel, Arthur P	125	Shawnee Mission, KS
Walker, Andrew	002	Leawood, KS
Waring, J. Michael	125	Kansas City
Watson, Timothy B	026	Columbia
Watson, Tom F	082	Springfield
***Weaver, Bruce E**	026	Columbia
Weaver, Mark E	082	Springfield
***Webb, James J**	102	Joplin
Wempe, Michael J	030	St. Joseph
Westcott, Bruce R	042	Jackson
Wilhite, Tria K	150	Shelbyville
Wilkinson, Linda	125	Kansas City
Williams, C. Mark	125	Kansas City
Williams, Todd L	102	Joplin
Wolff, Dolores P	190	St. Louis
***Wright, Michael D**	030	St. Joseph
Wright, Robert W, III	125	Kansas City
Yates, Charles L	026	Columbia
Yedlin, Jay H	125	Kansas City
Young, Kenneth R	082	Springfield
Youngblood, Frederick E	106	Crystal City
Zukaitis, Mark G	125	Kansas City

Cardiovascular Disease (CD)

Ahuja, Suraj P	125	Kansas City
Akin, C. David	125	Independence
Apprill, Phillip G	190	St. Louis
Ashley, Lillard G, Jr.	125	Kansas City
Bai, Samuel S	106	Festus

*Doctor of Osteopathy

Banerjee, Dilip	074	Washington
Barr, W. Kent	125	N. Kansas City
Beauchamp, Gary D	125	Shawnee Mission, KS
Biel, Stanley I	190	Bridgeton
Billadello, Joseph J	002	St. Louis
Bloom, Stephen A	125	Overland Park, KS
Bogart, Douglas B	125	N. Kansas City
Bresnahan, Dennis R	125	Kansas City
Callicoat, Paul E, Jr.	102	Joplin
Chapman, James B	042	Cape Girardeau
Chu, Paul R	125	Independence
Chun, Duck S	190	St. Louis
Cochran, David S	082	Springfield
Conn, Robert D	125	Kansas City
Cooksey, Jon D	190	St. Louis
Corcoran, Francis H	102	Joplin
***Cox, John M**	102	Joplin
Cupp, Gerald V	026	Columbia
Davis, J. Lawrence	190	St. Louis
Deane, Louis V, Jr.	190	St. Louis
Dwyer, James G	190	St. Louis
Earnest, James B	125	Kansas City
Fagan, Leonard F, Jr.	190	St. Louis
Farrar, Michael W	125	Merriam, KS
Freeman, James A	026	Columbia
Freiman, Paul C	082	Springfield
Gafford, Franklin H, IV	190	St. Louis
Gibson, Paul H	190	St. Louis
Glueck, Robert M	125	Kansas City
Godlewski, Krystof J	125	Kansas City
Good, Thomas H	125	Kansas City
Ha, Richard J	150	Hannibal
Hamilton, William P	190	St. Louis
Harshman, David M	190	St. Louis
Hartzler, Geoffrey O	125	Shawnee Mission, KS
Haycraft, Gordon L	042	Cape Girardeau
Hegde, S. Roy	125	Kansas City
Henry, Clarke L, Jr	125	Kansas City
Herman, Robert L	125	Kansas City
Hess, John P	190	St. Louis
Hills, Joe E	082	Springfield
Hindupur, Mohan R	030	St. Joseph
Huber, Kenneth C	125	Kansas City
Hubert, John W	190	Bridgeton
Jackson, Jay A	125	Kansas City
Jain, Savitri G	190	St. Louis
Johnson, Warren L, JR	125	Kansas City
Kennett, Jerry D	026	Columbia
Kilgore, John W	190	St. Louis
Kindred, Lynn H	125	Kansas City
Kistler, W. David , Jr.	190	St. Louis
Kroetz, Frank W	202	Sikeston
LaFoe, William K	042	Cape Girardeau
Laughlin, Edward J	125	Independence
Lawrence, Willie E, Jr.	125	Overland Park, KS
Lee, Gerald B	214	Kansas City
Lee, Jung H	106	Crystal City
Levi, Bernard	125	Overland Park, KS
Long, John W	026	Columbia
Love, Gerry A	125	Liberty
McCallister, Ben D	125	Kansas City
McConahay, David R	125	Kansas City
Meyer, Randall E	058	Jefferson City
Miller, John T	125	N. Kansas City
Mizell, Myron W	082	Springfield
Montgomery, Michael A	125	N. Kansas City
Moore, Thomas B	102	Joplin
Mukharji, Jhulan	125	Kansas City
Musick, William D	026	Jefferson City
Myears, Donald W	082	Springfield
Nordlicht, Scott M	190	St. Louis
Oliver, G. Charles	002	St. Louis
Ostrow, Louis B	042	Cape Girardeau
Penilla, Antonio R	190	St. Louis
Politte, Lenard L	026	Columbia
Porter, Charles B	125	Kansas City
Riner, Ronald N	190	St. Louis
Roselman, Michael J	082	Springfield
Rutherford, Barry D	125	Kansas City
Ruwitch, Joseph F, Jr.	190	St. Louis
Sanders, Jack S	058	Jefferson City
Scharf, Daniel	125	Overland Park, KS
Shimshak, Thomas M	125	Kansas City
Spadaro, James J	190	St. Louis
Spitler, Allen L	042	Cape Girardeau
Spurny, Otto M	125	Kansas City
Stahl, Lloyd D	125	Overland Park, KS
Stauffer, Robert C	102	Joplin
Steinhaus, David M	125	Kansas City
Stickley, Louis P	190	St. Louis
Stuppy, Robert J	102	Joplin
Sweeney, Michael J	125	Kansas City
Talbert, Clifford R	042	Cape Girardeau
Valuck, Richard P, Jr.	150	Hannibal
Weiss, Alan N	190	St. Louis
Whiting, Richard B	190	St. Louis

Cardiovascular Surgery (CDS)

Bailey, Colin E	026	Columbia
Borkon, A. Michael	125	Kansas City
Bryant, Lester R	026	Columbia
Crouch, John A	026	Columbia
Curtis, Jack J	026	Columbia
Demmy, Todd L	026	Columbia
Ewy, Marvin F	026	Columbia
Foley, Jonathon K	042	Cape Girardeau
Freund, William L	125	N. Kansas City
Hannah, Hamner , III	125	Prairie Village, KS
Hiremath, Yoganand J	102	Joplin
Johnson, Fritz M	082	Springfield
Kase, James B, Jr.	125	N. Kansas City
Kramer, Jeffrey B	125	Prairie Village, KS
Lammoglia, Francisco J	030	St. Joseph
Laster, Steven B	125	Kansas City
Mangalat, Narayanan K	102	Joplin
McCroskey, Brian L	125	Kansas City
Morrison, Stephen K	082	Springfield
Pinckley, James N	082	Springfield
Reinsvold, Thomas M	102	Joplin
Retter, Kenneth W	042	Cape Girardeau
Rigden, L. Brick	125	N. Kansas City
Rogers, James D	082	Springfield
Ruff, Paul G	082	Springfield
Schmaltz, Richard A	026	Columbia
See, W. Mike	026	Columbia
Stamatis, John J	082	Springfield
Starr, Steven K	125	N. Kansas City
Voelker, Donald J	026	Columbia
Walls, Joseph T	026	Columbia

Child Neurology (CHN)

Dodge, Philip R	190	St. Louis
Mantovani, John F	190	St. Louis
Prensky, Arthur L	190	St. Louis

Child Psychiatry (CHP)

Alfie, Salomon	125	Shawnee Mission, KS
Birchansky, Bonnie-Lee	030	St. Joseph
Buchanan, Barbara N	125	Kansas City
Daniel, A E	026	Columbia
Edwards, James E	190	St. Louis
Huk, Stephen G	050	Overland Park, KS
Lorenzo, Edilberto B	034	Poplar Bluff
Moore, Harry G, Jr.	190	St. Louis
Sumer, Emel A	190	Bridgeton

*Doctor of Osteopathy

Clinical Pathology (CLP)

Druet, Robert L	082	Springfield
Haake, Gregory K	082	Springfield
Nomura, Roy M	190	St. Louis
Posey, Douglas H, Jr.	030	St. Joseph
Raborar, Arteso C	082	Springfield
Thal, Sanford M	190	St. Louis
Withrow, Donald	190	St. Louis

Colon & Rectal Surgery (CRS)

***Abbadessa, Steven M**	190	St. Louis
Brabbee, Gregory W	190	St. Louis
Cirocco, William C	125	Shawnee Mission, KS
Fleshman, James W	190	St. Louis
Gose, Don F	082	Springfield
Graham, Bruce D	125	Shawnee Mission, KS
Kodner, Ira J	190	St. Louis
Robbins, Philip L	190	St. Louis

Critical Care Medicine (CCM)

Cohen, Reuben J	082	Springfield
Hata, J. Steven	026	Columbia

Dermatology (D)

Ailor, Susan K	026	Columbia
Albert, I. Renee	190	St. Louis
Anderson, Daphne W	082	Springfield
Anderson, Frank K	189	St. Charles
Anderson, Philip C	026	Columbia
Aronberg, Jerome M	190	St. Louis
Ashby, Jennifer D	125	N. Kansas City
Bailey, Hugh R	002	Kansas City
Bauschard, Frederick D	190	St. Louis
Chanasue, John A	190	Florissant
Creech, Fred T	026	Columbia
Dempsey, Kenneth J	202	Sikeston
DeSpain, John D	026	Columbia
Dilworth, Jacquelyn B	190	St. Louis
Dyer, Gary A	030	St. Joseph
Eisen, Arthur Z	190	St. Louis
Foote, Jerry E	026	Columbia
Forsman, Karen E	190	St. Louis
Gentry, Michael A	082	Springfield
Griffin, Darrell L	138	Farmington
Gunn, Victoria	058	Jefferson City
Gunnoe, Robert E	125	Kansas City
Hall, John C	125	Kansas City
Hilton, Paul E	102	Joplin
Hironimus, John E	190	St. Louis
Hruza, George J	190	St. Louis
Hruza, Luciann L	002	St. Louis
Johnson, Dallas A	125	Overland Park, KS
Lane, Daniel K	190	St. Louis
Levenson, Ina	034	Poplar Bluff
Lynch, Thomas W	082	Springfield
Major, Troy E	082	Springfield
Marrs, David B	189	St. Charles
Matlock, Mark S	102	Joplin
McCadden, Michael E	190	St. Louis
McCloud, Deborah J	102	Joplin
Medler, P. Louis	190	St. Louis
Melia, B J, Jr.	125	Kansas City
Miller, Charles W	190	St. Louis
Morrow, N. Eugene	082	Springfield
Oleson, Gale B	125	Blue Springs
Palmer, Stephen M	190	St. Louis
Payne, David E	026	Columbia
Portnoff, Lee S	190	St. Louis
Powell, John A	190	St. Louis
Reese, Lester T	190	St. Louis
Roller, James A	026	Columbia
Scott, Jamie A	082	Springfield
Shatley, Miriam J	058	Jefferson City
Simmons, Jess S	102	Joplin
Stoecker, William V	135	Rolla
Swinfard, Ronald W	026	Columbia
Thomas, F. Anthony	050	Kansas City
Tiefenbrunn, Sharon F	190	St. Louis
Tucker, Dolores R	190	Chesterfield
Uhlemann, John H	189	St. Charles
Vitale, Stephen J	190	Chesterfield
Walsh, Richard J	030	St. Joseph
Werth, Joseph A	058	Jefferson City
Wolfe, Edward M	190	St. Louis
Zanol, Karen E	026	Columbia
Zurowski, Susan M	026	Columbia

Diagnostic Radiology (DR)

Amini, Jafar	125	Shawnee Mission, KS
Anderson, David R	042	Cape Girardeau
Anthony, James P	125	Kansas City
Applewhite, Thomas A	190	St. Louis
Balfe, Dennis M	190	St. Louis
Bartlett, John E	082	Springfield
Barton, Premsri T	190	St. Louis
Beal, Catherine E	190	St. Louis
Belshe, Sidney B	058	Jefferson City
Brent, Lanny R	082	Springfield
Brown, Mike J	042	Cape Girardeau
Carlton, Lynn N	082	Springfield
Churchill, Robert J	026	Columbia
Cooper, Barry R	050	N. Kansas City
Cram, John W	082	Springfield
Crepps, Louis F	190	St. Louis
Cronemeyer, Richard L	125	Lee's Summit
Cusumano, Joseph V	190	St. Louis
Cyriac, George K	014	Mexico
Davis, Gene L	190	St. Louis
Dell, Robert V	150	Hannibal
Dever, Robert L	102	Joplin
Devkota, Jagadishwar	026	Columbia
Dierberg, Dale F	074	Chesterfield
Engels, John T	002	St. Louis
Ernst, Edwin C, III	190	St. Louis
Evens, Ronald G	190	St. Louis
Fisher, James K	125	Kansas City
Fletcher, Dale M	002	St. Louis
Foss, Jonathan M	190	St. Louis
Francis, Roger A	120	Linn Creek
Gafarian, Kathleen	082	Springfield
Garvin, Charles F	190	St. Louis
Gehm, Louis E	214	Butler
Geisse, Guillermo	190	St. Louis
Gennaoui, Jad M	190	St. Louis
Gibson, Merlyn D	026	Columbia
Glazer, Harvey S	190	St. Louis
Goodhope, Karen F	190	St. Louis
Graviss, E. Richard	190	St. Louis
Greditzer, Harry G	190	St. Louis
Gresick, Robert J, Jr.	190	St. Louis
Hall, Bryan K	082	Springfield
Hardy, Jeffery A	190	St. Louis
Hedgepeth, Bruce L	082	Springfield
Hillard, Alan E	026	Columbia
Hoffman, Mark J	190	St. Louis
Horner, Charles W	125	Kansas City
Idstrom, Mark E	125	Kansas City
Jones, Maynard C, Jr.	125	Lee's Summit
Jones, Paul S	102	Joplin
Junker, James A	106	St. Louis
Keller, Stephen M	190	St. Louis
Kelling, E. Collyer	082	Springfield
Koontz, Kenneth L	125	Kansas City
Krahn, Michael J	050	Kansas City

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Kuckelman, Richard G	Kansas City	125
Lee, H. T.	Columbia	026
Lepkowski, Hemlata K	Columbia	026
Levine, Richard S	St. Louis	190
Levitt, Robert G	St. Louis	190
MacDonald, Robin R	Kansas City	125
Martin, David S	Chesterfield	190
Mayes, Ben R	St. Louis	190
McManus, Gerald	N. Kansas City	050
Merkle, John A	St. Louis	190
Moore, Michael T	Nevada	214
Morgan, John L	Springfield	082
Mosher, Amy A	St. Louis	002
Nelson, David E	Springfield	082
Olson, Robert J	Springfield	082
Omell, Gary H	St. Louis	190
O'Toole, Patrick M	Kansas City	125
Pohl, David L	St. Louis	190
Pottenger, L. Kenneth	Joplin	102
Price, Hilton I	St. Louis	190
***Radinsky, Stephen**	St. Louis	190
Rosenthal, Debra D	St. Louis	190
Sadhu, Vijay K	Columbia	026
Sanders, Harold L	Columbia	026
Sauer, James M	Springfield	082
Scearce, Robert L	Jefferson City	058
Scheible, Robert F	St. Louis	190
Schwegler, Robert G	Shawnee Mission, KS	125
Seelig, Robert D	St. Louis	002
Shaplin, Alfred D	Ballwin	106
Smid, Anne A	Springfield	082
Smith, Emily L	St. Louis	190
Sobky, George H	Louisiana	190
Soha, Joseph J, Jr.	Columbia	026
Stevens, Edward M	St. Joseph	030
Stewart, James G	St. Louis	190
Stoecker, Willeford J	Cape Girardeau	042
Sullivan, Dan T	Springfield	082
Sullivan, David M	Springfield	082
Sullivan, John A	Springfield	082
Swaney, Charles M	Columbia	026
Sweeney, Thomas P	Springfield	082
Szoko, Edward	St. Louis	190
Thalblum, Harvey	Kansas City	125
Thomasson, Jeffrey L	St. Louis	190
Tobler, Jerry	St. Louis	190
Totty, William G	St. Louis	190
Trotta, Philip C	St. Louis	190
Vannier, Michael W	St. Louis	190
Vas, Wenzel G	St. Louis	190
Weis, Ronald R	Kansas City	125
Wiele, Kimberly N	St. Louis	190
Wilcox, Dennis M	Leawood, KS	125
Wilson, J. Mark	Springfield	082
Wolski, James R	Springfield	082

Emergency Medicine (EM)

Adkins, Charlene	Columbia	026
Ahmad, Salama S	Chesterfield	190
Ammala, Edward D	Rolla	135
Barrow, Chelmer L, Jr.	Lake St. Louis	190
Bell, Malinda H	Shawnee Mission, KS	125
Berry, Danny T	Cape Girardeau	042
Blaine, James R	Springfield	082
Bonney, Saml C	Washington	074
Carter, Gary L	N. Kansas City	050
Criscione, James R, Jr.	St. Louis	190
DeCoursey, Kenneth A	Cape Girardeau	042
***Draper, Richard E**	Cape Girardeau	042
DuMontier, Alan J	Chesterfield	190
Gambill, Gary L	Chesterfield	190
Grisham, Thomas D	Washington	074
Hassen, Mark A	St. Louis	002
Hicks, Robb R, IV	Cape Girardeau	042
Hierholzer, Rebecca S	N. Kansas City	125
Jordan, Janet C	Springfield	082
Judge, Steven J	Washington	074
Julien, Rene	Belleville, IL	190
***Karr, Jerry L**	Cape Girardeau	042
Keesal, Dennis	St. Charles	189
Kensel, Robert S	Rogersville	082
Kolda, Michael A	Cape Girardeau	042
Labayen, Ricardo A	Overland Park, KS	125
***Landers, Gary A**	N. Kansas City	050
Lewis, Lawrence M	St. Louis	190
Lewis, William S	Cape Girardeau	042
Lorei, John M	Kansas City	002
McEnroe, John D, Jr.	Kansas City	125
McIntosh, Douglas A	Cape Girardeau	042
McMurry, Ted A	Springfield	082
***Mitchell, Richard N**	Cape Girardeau	042
Mobley, Gilbert L	Springfield	082
Moranville, Benedict A	St. Joseph	030
Morgan, Edward B	St. Louis	190
Nelson, Michael J	Lee's Summit	125
Newport, Mark D	Springfield	082
Pancoast, Charles H	Cape Girardeau	042
Parks, William C	Columbia	026
Patel, Raman J	St. Joseph	030
Poggemeier, David A	St. Charles	189
Prickett, David C, Jr	Kearney	050
Psaltis, Phillip E	Kansas City	030
***Ramsey, Jesse R**	Cape Girardeau	042
Ratcliff, Keith M	Washington	074
Ricci, Walter J	Kansas City	125
***Roberts, Rebecca L**	Kansas City	030
Robinson, William A	Kansas City	125
Rush, Marvin R	Ste. Genevieve	174
Russell, Steven L	Kansas City	050
Scarborough, Betty F	Shawnee Mission, KS	125
Scarborough, Mark R	Kansas City	125
Selove, Peter T	Joplin	102
Skeins, Edward J, Jr.	Springfield	082
Smith, Earl E, III	Bridgeton	190
Smith, Norman A	Columbia	026
Steele, Mark T	Kansas City	002
Stoliar, John B	St. Louis	190
Sullivan, Christine	Overland Park, KS	125
Svancarek, William P	St. Louis	190
Szewczyk, Michael J	Columbia	026
***Turner, Timothy T**	Barrington, IL	002
Velander, Robert D	Blue Springs	125
Weaver, Michael L	Kansas City	125
Weber-Bornstein, Nancy	Cape Girardeau	042

Endocrinology (END)

Duda, Ralph J, Jr.	Springfield	082
Duick, Daniel S	Cape Girardeau	042
Hellman, Richard	N. Kansas City	125
Henson, Bruce E	Kansas City	125
James, Ronald C	Columbia	026
Koppers, Lawrence E	Springfield	082
Porte, Karen L	Joplin	102
Quick, William W	Kansas City	125
Rosen, Howard M	N. Kansas City	125

Facial Plastic Surgery (FPS)

Buchwach, Kenneth A	Independence	125
deLeeuw, Karel A	Springfield	082
LaFerriere, Keith A	Springfield	082
Prstojevich, Steven J	Kansas City	125
Simo, Frank	St. Louis	190
Tanner, John P	Kansas City	125
Thomas, J. Regan	St. Louis	190

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Family Practice (FP)

Abu Dalu, Ziad	190	St. Louis
Adams, Stephen R	082	Springfield
*Adkison, Brian W	082	Seymour
Ahnemann, Janet L	086	Clinton
Allan, James E	058	Jefferson City
Allcorn, Donald K	178	Lincoln
Anglo, Luis B	190	St. Louis
*Asher, Kennett D	042	Jackson
Askew, John H	202	Sikeston
Auner, J. David	138	Ironton
Baker, Carl N	190	St. Louis
Baker, Donald L	074	Union
Barbe, David O	206	Mountain Grove
Batty, Thomas V	214	Eldorado Spngs
Belden, Jeffery L	026	Columbia
Bellamy, Bruce G	086	Clinton
Benedict, Holly J	082	Ozark
Bennett, John E	058	Jefferson City
Berner, Carol T	082	Springfield
Bernhardt, Gary D	125	Overland Park, KS
*Betz, William T	125	Grandview
*Bieser, R. Dan	042	Cape Girardeau
*Billings, Christopher W	082	Springfield
Binz, Donald E	189	St. Peters
Birkby, William F	026	Columbia
Boatright, Kevin	138	Farmington
*Bohn, Sara A	058	California
Bowles, Richard P	050	Liberty
Boydston, Catherine O	118	Odessa
Boydston, Wyatt W	118	Odessa
Bradley, J. Douglas	030	St. Joseph
Brockhaus, Jayne R	110	Warrensburg
Brown, Merlin D	030	St. Joseph
Brunworth, David	074	Washington
Buffaloe, Robert N	058	Jefferson City
Buie, Steven E	125	Kansas City
Bumberry, Barbara A	082	Springfield
Burcham, Tom R	042	Farmington
*Bynum, Robert L	026	Ashland
Byrum, Fritz A	190	Ballwin
Cady, Roger K	082	Springfield
Caldwell, Fred	034	Poplar Bluff
Campbell, Albert J	178	Sedalia
Carey, Larry J	082	Springfield
Carney, Stephen E	202	Sikeston
Carr, George W	058	Jefferson City
Carranza, Mauro J	190	St. Louis
Carter, James E, Jr.	125	Leawood, KS
Caster, Philip W	115	Lebanon
Catron, David O	042	Cape Girardeau
Chaffin, Jerald D	208	Branson
Chambon, Gregory E	125	Kansas City
*Chandra, Ram	118	Higginsville
Chastain, Charles W	138	Bonne Terre
Chavez, Salvador	190	St. Louis
*Claxton, Carl D	082	Springfield
Collison, R Michael	082	Springfield
Colwill, Jack M	026	Columbia
Comfort, George D	014	Mexico
Covert, Richard A	190	St. Louis
Cravens, David D	026	Centralia
Cravens, William P	038	Fulton
Crespo, Horacio T	074	Warrenton
Crespo, Remedios R	074	Warrenton
Crist, Roderic C	042	Cape Girardeau
Dahlberg, Thomas E	082	Springfield
Dang, Robert C	214	Pleasant Hill
Davis, Carl S	125	Lee's Summit
Dean, Walter E	158	Maryville
DeLine, Jim	046	Macon
Dempsey, Herbert A	125	Lee's Summit
*Dempsey, Herbert E	125	Lee's Summit
Devabhaktuni, Rama Devi	190	Chesterfield
Dickerson, Malcolm J	058	Eldon
Dierker, Harry D	026	Columbia
Dimayuga, Nestor G	206	Mansfield
Dixon, Druery J	206	West Plains
Dodson, Jack M	058	Jefferson City
Domke, Henry F	058	New Bloomfield
Donnell, Harold E	106	De Soto
Donnell, William S, Jr	066	Bolivar
Dougherty, Thomas M, Jr.	054	Gladstone
Downey, Jon P	042	Cape Girardeau
*Dunn, Roxanne M	030	Wathena, KS
Dunshee, Robert E	158	Maryville
Dyer, Curtis W	110	Warrensburg
Ekern, H. Peter	014	Mexico
Elcock, Devera M	190	St. Louis
*Eldenburg, Steven C	178	Sedalia
Elfrink, Melanie Eden	198	Marshall
Elliott, Wendell H	034	Poplar Bluff
Fakhoury, Donald A	050	Kansas City
Florence, Kerry E	074	Washington
Fowler, Marvin L	206	West Plains
Franey, Michelle R	125	Kansas City
Frazier, Robert L	202	Sikeston
*Fry, John M	082	Springfield
Galbraith, Polly M	125	Kansas City
Gilbirds, William M, II	050	Kansas City
Glover, David	110	Warrensburg
Goff, John E	102	Joplin
Good, Michael W	082	Springfield
Grechus, John J	138	Farmington
Green, William R	190	St. Louis
Greenlund, Nelson C	214	Nevada
Griffith, S Kent	042	Cape Girardeau
Groce, George D	038	Fulton
Hall, Terry E	078	Bethany
Halverson, Larry W	082	Springfield
Hamid, Rashid S	198	Marshall
*Hancock, Thomas J	058	Jefferson City
Hardy, Stanton L	138	Desloge
*Hare, Thomas	082	Springfield
Harr, Patrick B	158	Maryville
Harris, Louis B	066	Bolivar
Hayden, Melvin R	120	Camdenton
Hayes, Lawrence L	050	Kansas City
Hayes, Nancy J	206	Mountain Grove
Hedrick, Frances A	058	Holts Summit
Hernandez, J. Humberto	074	Gerald
Herrmann, Deborah A	198	Marshall
Heutel, Lee B	190	St. Louis
Hite, Dennis E	115	Lebanon
Hoffmann, Alan L	125	Kansas City
Hofmeister, Roger W	026	Columbia
Holley, Donald B	082	Springfield
Holzem, Craig S	074	Washington
Hopkins, Thomas A	082	Springfield
Howell, David T	002	Florissant
Hrabik, Brent	158	Tarkio
Hubbard, Sally L	082	Springfield
Huffman, Larry	208	Branson West
Huguenard, Joseph R	190	St. Louis
Humphrey, James D	158	Mound City
Hunter, James K, Jr.	158	Fairfax
Huss, Randall D	135	Rolla
Icaza, Ramiro	042	Jackson
Inocentes, Fe A	189	O'Fallon
*Isaacs, Victor E	042	Scott City
Jackson, Max G	125	Kansas City
Jenkins, Edward R	135	Waynesville
Johnson, Joseph E	125	Kansas City
Johnson, Lent C	150	Hannibal
Johnson, Patrick E	138	Farmington
Jones, Gordon	202	Sikeston
Jones, Justin E	014	Mexico

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Kairuz, Bartolome C	**190**	St. Louis
Kanne, Marty A	**050**	Kansas City
Kapp, Dave	**174**	Perryville
Kappesser, Netajean G	**190**	St. Louis
Kasten, Mark C	**042**	Cape Girardeau
Kenney, Douglas R	**086**	Clinton
Kessler, William D, Jr.	**102**	Joplin
Kimlinger, William R	**058**	Jefferson City
Kinder, Doyle O	**082**	Springfield
Klein, Kendel L	**166**	Mount Vernon
Koon, Ben H	**066**	Bolivar
Kraemer, Edwin T	**125**	Lee's Summit
Kruse, Carl R	**150**	Palmyra
Laatsch, Robert H	**034**	Poplar Bluff
Laiben, Gregg R	**125**	Kansas City
Lauber, Joseph J	**190**	St. Louis
Lavery, Daniel P	**058**	Westphalia
***Law, Byron D**	**050**	Kansas City
Lee, Susan L	**125**	Kansas City
Legler, Larry E	**125**	Independence
Leroux, Gene H	**034**	Doniphan
Lisbon, Eleanor A	**125**	Kansas City
Lischwe, Daniel H	**190**	Bridgeton
Loeb, Mark	**026**	Columbia
Lofgreen, Craig S	**002**	Kansas City
Long, Timothy P	**074**	Marthasville
Lueckenhoff, Rebecca R	**058**	Jefferson City
Luerding, Jeffrey A	**050**	Kansas City
Lukavsky, James P	**208**	Branson
Lutkewitte, Joseph F	**174**	Ste. Genevieve
Lyle, Robt R	**120**	Versailles
Madden, Michael L	**125**	Kansas City
Markway, Gregory A	**125**	Independence
Marshall, William G	**026**	Glasgow
Martin, Mark W	**125**	Lee's Summit
Martin, Robert A	**206**	West Plains
Mason, Mary Jane	**135**	Steelville
Masters, Edwin J	**042**	Cape Girardeau
McDowell, James W	**014**	Mexico
McFarland, Rodney J	**166**	Neosho
McQue, Ellen L	**150**	Hannibal
Mehaffy, Orville A	**102**	Joplin
Mehr, David R	**026**	Columbia
Meier, Francis X	**058**	Jefferson City
***Melchior, David E**	**174**	Perryville
Memken, John A	**150**	Hannibal
Menchetti, Donald E	**082**	Springfield
Meyer, Jerry L	**118**	Concordia
Miller, William D	**030**	St. Joseph
Molberg, Peter J	**082**	Springfield
Montes, Arturo C	**190**	Florissant
Morgan, W. Tom , Jr.	**026**	Columbia
Morton, Wayne L	**214**	Osceola
Mueller, Randall E	**026**	Columbia
Munger, Michael L	**125**	Kansas City
Myers, Carl M	**125**	Platte City
Nadolski, Gary S	**030**	St. Joseph
Newman-Koehn, Mica K	**198**	Marshall
O'Connor, John J	**074**	St. Louis
Ojascastro, Alejandro C	**190**	St. Louis
O'Rourke, James E	**174**	Ste. Genevieve
Ortiguero, Leopoldo M	**190**	St. Louis
Osbourn, Richard A	**038**	Fulton
Ostergaard, Daniel J	**125**	Kansas City
Ouellette, David F	**150**	Hannibal
Palen, James E	**042**	Cape Girardeau
Papreck, K T	**198**	Marshall
Paris, William H	**190**	Bridgeton
Patterson, Donald R	**102**	Joplin
Pennington, Michael S	**166**	Springfield
***Perry, Christopher M**	**002**	St. Louis
Phillips, Kenneth D	**042**	Cape Girardeau
Phillips, Ronald L	**148**	Kirksville
Piker, K. Dewayne	**082**	Springfield
Pimentel, Esperanza M	**190**	St. Louis
Pinkham, Chris M	**050**	Kansas City
Pitney, Phillip W	**150**	Louisiana
Poggemeier, William H	**189**	St. Charles
Pon, Marcelino	**190**	St. Louis
Potts, Donald A	**125**	Kansas City
Presley, Jimmy C	**082**	Springfield
Preston, Bruce E	**206**	West Plains
Prica, George , Jr	**026**	Columbia
Price, Richard C	**214**	Harrisonville
Randolph, Bernard C	**190**	St. Louis
Rapp, Earl L	**150**	Hannibal
Reeder, Charles C	**050**	Smithville
Reifeiss, Jerry S	**070**	Campbell
***Reno, Lisa K**	**018**	Lamar
Reust, Carin E	**082**	Springfield
Reyes, Luis A	**190**	Arnold
Reynolds, Susan K	**190**	St. Louis
Rhee, Seoung E	**190**	St. Louis
Richardson, George A	**074**	Union
Roach, Mona S.I.	**125**	Prairie Village, KS
Robbins, Thomas D	**058**	Jefferson City
Roberts, Theodore W	**202**	Sikeston
Robertson, William D	**034**	Poplar Bluff
Rogers, H. Bryan	**190**	St. Louis
Rosen, William K	**082**	Springfield
Royce, Debra L	**102**	Sarcoxie
Rues, Lawrence A	**125**	Kansas City
Ryan, David	**078**	Trenton
Scharrer, Alan J	**002**	Lee's Summit
Schmitz, Ralph A	**166**	Monett
Schutz, John P	**050**	Excelsior Springs
Scott, E. David	**058**	Jefferson City
Scott, Hillard L	**190**	St. Louis
Scott, Kenneth F	**086**	Clinton
Seale, Stuart A	**082**	Springfield
Shaw, James T	**074**	Hermann
Shaw, Robert D	**206**	Willow Springs
Shields, Lawrence S	**082**	Springfield
Shinn, Michael E	**050**	Kansas City
***Shoop, Jill E**	**082**	Springfield
***Sill, William**	**189**	St. Peters
Silvers, L. Michael	**125**	Kansas City
Sincox, Charles H	**074**	Washington
Sitzmann, Bryan L	**050**	Kansas City
Slaughter, Larry	**026**	Columbia
Smith, Claude F	**206**	Willow Springs
Smith, Gilbert D	**034**	Poplar Bluff
Sparkman, Thomas C	**042**	Cape Girardeau
Spence, Paul A	**042**	Cape Girardeau
Spencer, Donald C	**026**	Fulton
Spurlock, Luther D	**135**	Rolla
Spurney, Joe E	**125**	Kansas City
Steele, Jack T	**190**	Bridgeton
Steenbergen, Michael	**058**	Jefferson City
Steiner, Marvin P	**125**	Independence
Stelmach, Walter J	**125**	Kansas City
Stone, Kenneth D	**202**	Sikeston
Stringer, Kenton L	**166**	Aurora
Stuerman, Lawrence G	**150**	Louisiana
Suarez, Alberto	**125**	Lee's Summit
Tegtmeyer, Chris	**115**	Lebanon
Theby, Janet E	**058**	Eldon
Thies, Jerome H	**214**	Osceola
Thomas, Deborah G	**042**	Cape Girardeau
Thompson, Frederick L	**214**	Nevada
Thompson, James E	**082**	West Plains
Thompson, Scott W	**125**	Kansas City
Till, Bennie N	**034**	Poplar Bluff
***Tipton, Richard J**	**042**	Cape Girardeau
Tobin, Marla J	**118**	Higginsville
Treadwell, Randall E	**190**	Chesterfield
Turner, James D	**074**	Washington
Turner, Kirby L	**034**	Poplar Bluff

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Uketui, Ozoemenam I	St. Joseph	030
***Upton, Gary L**	Columbia	026
Van Buren, Wilbur D	Kansas City	002
Van Zanten, Niko A	Osceola	214
Vargas, Teodoro C	Pacific	190
Vigneron, Eugene A	Jefferson City	058
Villahermosa, Juanito L	Savannah	010
Voszler, Richard B	Cape Girardeau	042
Ward, Mark R	Springfield	082
Wardell, M. Annette	Springfield	082
Watts, Samuel M	Mt. Vernon	166
Weiss, James J	Jefferson City	058
***Wescott, Thomas P**	Holden	110
Weston, Kenneth G	Columbia	026
Wheeler, Robert L	Harrisonville	214
Williams, Paul A	Kansas City	125
Williams, Paul A	St. Louis	002
Williamson, Blake J	Overland Park, KS	125
Williamson, Harold A	Columbia	026
Williamson, Paul S	Kansas City	002
Wilson, David E	Smithville	050
Wilson, Timothy A	Kansas City	050
***Wilson, W. Timothy**	Springfield	082
***Woodward, Owen L**	Atlanta	046
Workman, George M	Hermann	074
***Wright, James C**	Perryville	174
Wulfers, Michael C	Cape Girardeau	042
Wurm, Michael J	Maryville	158
Wurr, Dieter H	Arnold	190
***Yocum, Russell S**	Platte City	125
Young, Robert B	Rolla	135
Zanol, John M	Columbia	026

Gastroenterology (GE)

Allen, Mark J	Kansas City	125
Barber, Gregory B	Kansas City	125
Brock, Arthur L	Independence	125
Clement, Donald J	Kansas City	125
Coleman, Matthew J	Cape Girardeau	042
Coleman, Terrence W	Kansas City	125
Cooper, Gary D	Liberty	050
Culver, Perry J, Jr.	Kansas City	125
Cusworth, Robert	St. Charles	189
***Deffenbaugh, Larry D**	Joplin	102
Edwards, Dean A	Cape Girardeau	042
Farrell, John S	Bridgeton	190
Fedotin, Michael S	Kansas City	125
Frederickson, Neil W	St. Louis	190
Freeman, Michael R	Cape Girardeau	042
Freilich, Brad L	Kansas City	125
Geisman, Richard A	St. Peters	189
Ginsberg, B. William	Kansas City	125
Gordon, Glenn L	Mexico	014
Gurian, Lawrence E	Springfield	082
Helzberg, John H	Kansas City	125
Honaas, Trygve O	Cape Girardeau	042
Hover, Alexander R	Springfield	082
Jennett, Richard B	Jefferson City	058
Kaster, Steven D	Kansas City	125
Kipfer, Robert E	Springfield	082
Kouo, Louis	Cape Girardeau	042
Landers, Burnell	Independence	125
Lee, Wilfred	Cape Girardeau	042
Libel, Roy D	Springfield	082
Marshall, Jay P, II	Chesterfield	190
McCullough, Joseph E	Kansas City	125
McPhee, Mark S	Kansas City	125
Mentgen, Carl N	Springfield	082
Pelican, George	St. Louis	190
Petersen, James H	Chesterfield	002
***Schneider, Horace L**	Cape Girardeau	042
Shell, William C	Sikeston	202
Shuler, Frederick N	Kansas City	125
Stein, Bernard	Joplin	102
Taormina, Marc K	Independence	125
Walden, David T	St. Louis	002
Wooten, Michael B	Springfield	082

General Practice (GP)

Akers, Joan E	Kansas City	125
Akremi, Janet E	Warrensburg	110
Allan, James R	Columbia	026
***Andrews, Lynthia B**	Lexington	030
***Bader, Larry W**	Columbia	026
Baldwin, Theodore R	Excelsior Springs	118
Baumann, Albert R	Steelville	135
Butler, Susan M	Jefferson City	058
Campbell, James E	Macon	046
Campbell, James W	Advance	202
Carleton, Charles E	Farmington	138
Carpenter, Wallace	Rock Port	158
Choudhury, M. Hasan	Houston	206
Conant, James F	St. Joseph	030
***Courter, Gary M**	Lebanon	115
Dettmer, Robert F	Ironton	138
Eldenburg, Donald O	Sedalia	178
Frein, Donald E	Harrisonville	214
Gallemore, Rex A	Neosho	102
Gavini, Rajendra R	St. Louis	190
***Gayle, David R**	Piedmont	034
***Gayle, Richard E**	Piedmont	034
Grable, James D	Cape Girardeau	042
Gunn, Jack	Versailles	120
Haynie, William W	Butler	214
Heath, Jimmy D	East Prairie	202
Hettinger, Brenda A	Camdenton	120
Howell, Billy D	Brookfield	078
Howitt, William J	Springfield	082
***Hutchins, Sherry S**	Waynesville	135
Jahanian, Iraj	Springfield	082
Karraker, Alvan G	Farmington	138
Kauffman, Ruth	Versailles	120
Ladd, Charles B	St. Louis	190
Lankford, Harold D	Mexico	014
Lichty, Chas A	Shelbina	150
***Lillig, James F**	Kansas City	050
Long, Curtis W	Butler	214
Magaw, David C	Everton	066
Magruder, Lyell M	Nevada	214
McFadden, Gene A	Waverly	118
Menne, Marvin C	Ironton	138
Millwee, Elizabeth M	Centralia	026
Moore, Michael R	West Plains	206
Morehead, William E	Malden	070
Morris, John J	Columbia	026
Morrison, Thomas A	Aurora	166
Ozenberger, Larry A	Plattsburg	054
Painter, Andrew E	Portageville	202
Pavlu, Robert R	Waverly	118
Pehlman, Joseph E	Malden	070
***Pewitt, Charles S**	Jackson	042
Raynor, Richard C	Marshall	198
Reed, Glen H	Appleton City	214
Rul-Lan, Carlos D	Kansas City	002
Sargent, Alden P	Sikeston	202
Schaaf, Robert O	St. Joseph	030
Scowley, John E	Richmond	118
Shanahan, Philip J	St. Louis	190
Singh, Daljeet R	Higginsville	118
Smith, William J	Windsor	086
Tanner, Christina E	Springfield	082
Taylor, Steve J	Mexico	014
Villarama, Antonio P	High Ridge	190
Vinyard, Jack L	Joplin	102
Wall, Joe A	Houston	206
Won, Russell	St. Louis	190

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General Surgery (GS)

Aeder, Mark I	Kansas City	125
Afuwape, Emanuel A	E. St. Louis, IL	190
Albano, Benj I	Crystal City	106
Allen, Brent T	St. Louis	190
Almiron, Osias A	House Springs	190
Altepeter, H. Martin	St. Louis	190
Ancheta, Apolinario A	Springfield	082
Andres, Edward H	St. Joseph	030
Andrus, Charles H	Westchester, IL	190
Apostol, Andres G	Monett	166
Arbab, Ali A	Kansas City	125
Arenos, Proceso T	St. Louis	190
Arnold, Kenneth J	Chesterfield	190
Ashley, Michael E	Springfield	082
Ashley, Thomas E	Springfield	082
Ayvazian, Vatche H	St. Louis	190
Babka, Joseph J	St. Louis	190
Barr, Glenn A	Kansas City	125
Barragan, Hector D	St. Louis	190
Bartlett, Hugh C	Rolla	135
Bass, Barry J	Rolla	135
Bautista, Joel O	Moberly	046
Bautista, Rogelio L	Moberly	046
Beckman, Robert F	St. Louis	002
Beggs, Charles W	Liberty	050
Beheler, Edward M	St. Joseph	030
Behrends, Steven H	Kansas City	125
Behrens, Donald T	St. Louis	190
Benage, Clarence M	St. Louis	190
Bennett, Kenneth J	St. Louis	190
Bentlage, Charles H	Joplin	102
Bergmann, Daniel J	St. Peters	189
Berwald, David M	Bridgeton	190
Betz, Robert F	Neosho	166
Bhattacharya, Arjun	St. Louis	190
Billy, Lawrence J	St. Louis	190
Binnington, H B	St. Louis	190
Birnbaum, Elisa H	St. Louis	190
Bizek, J L	Aurora	166
Blank, Michael K	De Soto	106
Blanke, Thomas J	St. Louis	190
Bodney, Maj., Stephen A	Ft. Leonard Wood	135
Braverman, Stuart J	Sedalia	178
Breeding, Lyle G	Columbia	026
Brunt, L. Michael	St. Louis	190
Buckner, John W	Springfield	082
Buettner, John Brigham	Chesterfield	190
Bukstein, Michael J	Hannibal	150
Bumberry, John R	Springfield	082
Bussmann, Carl E	Bridgeton	190
Cabrera, Tomas V	St. Peters	189
Cannon, Max K	Kirksville	148
Cardwell, Daniel R	Bolivar	066
Cassat, James D	Washington	074
Castaneda, Marco A	Bridgeton	190
Catanzaro, Rudolph E	St. Louis	190
Cheuk, Shu-Sum	Chesterfield	190
Christiansen, Stephen D	Springfield	082
Christy, John P	Poplar Bluff	034
Chu, Peter Y	Kansas City	125
Chung, Kap Eun	Fredericktown	138
Chung, T. David	Poplar Bluff	034
Codd, John E	Bridgeton	190
Corrado, Joseph A	Mexico	014
Corry, Francis M	Springfield	082
Coscia, Robert L	Springfield	082
Craighead, Michael L	Jefferson City	058
Crighton, John C	Springfield	082
Critchlow, J. Thomas	Cape Girardeau	042
Daake, John W, Jr.	St. Louis	190
Dandridge, Walter C	Joplin	102
Doerhoff, Alan R	Jefferson City	058
Doerhoff, Carl R	Jefferson City	058
Dominquez, Jose M	Springfield	082
Donovan, John F	St. Louis	190
Duff, William M	Rolla	135
Dunn, Charles W	Springfield	082
Elfrink, Roy J	Marshall	198
Esparrago, F R	Monett	166
Evans, Joseph C, Jr.	Independence	125
Fabito, Daniel C	St. Louis	190
Fahrner, Mari A	Chesterfield	190
Fallon, Richard H	St. Louis	190
Floro, Mariano N	Florissant	190
Foreman, Phillip B	Hannibal	150
Fraser, Daniel M	St. Louis	190
Frohman, Boris	Sikeston	202
Gaul, Cpt., Mark P	Ft. Leonard Wood	135
Gerowin, Lance	St. Louis	190
Gibson, James D	Springfield	082
Gieselmann, James W	Poplar Bluff	034
Glenn, Edward A	Louisiana	150
Gomez, Cesar A	St. Louis	190
Gosek, Marek J	Warrensburg	110
Greene, Howard G	Louisiana	150
Guerra, Gaston G	Kansas City	125
Hahn, Bruce H	Lee's Summit	125
Hamre, Daniel W	La Grande, OR	082
Hanna, Hugh A	Warrensburg	110
Harms, James F	Nevada	214
Harris, Hugh S, Jr.	Columbia	026
Hayek, Michael E	St. Louis	190
H'Doubler, Charles	Mt. Vernon	082
H'Doubler, Francis T	Springfield	082
H'Doubler, Peter B	Springfield	082
Heeb, Max A	Sikeston	202
Helfrich, Loring	Sikeston	202
Helling, Thomas S	Kansas City	125
Hendren, Thomas H	Liberty	050
Hill, Ronald T	Dexter	202
Hoberock, Thomas R	Branson	208
Hoehn, John P, III	St. Louis	190
Hornbostel, Phillip M	Sedalia	178
Howard, Todd K	St. Louis	190
Humphrey, Paul W	Columbia	026
Hunt, Robert S	Cape Girardeau	042
Ivins, Gregory K	Fulton	038
James, Kathleen M	St. Charles	189
Jensen, Joshua E, II	St. Louis	190
Jew, Amie C	Overland Park, KS	125
Johnson, Frank E	St. Louis	190
Kakaiya, Dilip H	Kennett	070
Kang, Young M	West Plains	206
Kanlic, Enes M	Rolla	135
Kasten, Melvin C	Cape Girardeau	042
Kinder, Jerry L	Cape Girardeau	042
King, Frank K	Hayti	170
Kingsbury, Robert J	St. Peters	189
Knight, James W	St. Louis	190
Koivunen, Debra G	Columbia	026
Koontz, Paul G	Kansas City	125
Krajcovic, David P	Chesterfield	190
Kuvshinoff, Boris W	Columbia	026
LaHue, William C	Lexington	118
Larson, Kenneth W	Springfield	082
Laster, Jerry L	Joplin	102
Levy, Jerome F	St. Louis	190
Liang, Jing C	Independence	125
***Light, Diane L**	Jefferson City	058
Limpiphiphatn, Dhajphong	Perryville	174
Londe, Alan M	St. Louis	190
London, Stanley L	St. Louis	190
Long, W. Steven	St. Joseph	030
Lopez-Plata, Roberto	Leawood, KS	125
Lowell, Jeffrey A	St. Louis	190
Ludwig, Mark A	St. Louis	190

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Lugo, Saml	190	St. Louis
Lundman, Hugh	082	Springfield
Madrid, Dominador O	190	St. Louis
Marr, Garrett L	125	Kansas City
Martin, Clarence A	102	Joplin
Mayuga, Laureano G	206	Cabool
McCroskey, Lon C	125	Kansas City
McGinty, Frank H	042	Cape Girardeau
Meier, Mitchell S	102	Joplin
Metzler, Michael H	026	Columbia
Meyer, Robert C	190	St. Louis
Meyers, Jerry R	189	St. Peters
Miedema, Brent W	026	Columbia
Mitchell, Franklin L	026	Columbia
Moffe, Thomas C	082	Springfield
Monafo, William W	190	St. Louis
Morehouse, Paul D	074	Washington
Mosley, Julian C	190	St. Louis
Muhm, H. Yale	189	St. Charles
Mulder, George D	030	St. Joseph
Mutchnick, Norman	125	Kansas City
Nagle, Michael G	102	Joplin
Nathan, Lester J	190	Fenton
Near, David M	190	Florissant
Nelson, Paul W	125	Kansas City
Newman, Joseph A	102	Joplin
Niesen, Frank J	190	St. Louis
Niesen, Thomas E	190	Chesterfield
Nigro, Thomas L	125	Kansas City
Nwaobasi, Sam	190	Florissant
Occeno, Victor G	166	Cassville
Ochoa, Pedro	190	Valmeyer, IL
O'Farrell, Thomas P	125	Kansas City
Olive, G. Chapman	082	Springfield
Oliver, George A	138	Farmington
Olson, Richard O	189	St. Charles
Ong, Eng L	190	St. Louis
Parikh, Sharad P	190	Florissant
Parks, Charles	190	St. Louis
Parulekar, Dilip G	038	Fulton
Peick, Ann C	034	Poplar Bluff
Pennell, Richard C	190	St. Louis
Perez, Adamor R	190	St. Louis
Perll, Peter D	014	Mexico
Petelin, Joseph B	125	Shawnee Mission, KS
Peters, Walter R	026	Columbia
Petit, Carl A	120	Osage Beach
Philpott, Gordon W	190	St. Louis
Pitsinger, N. Bruce	190	Chesterfield
***Pitt, James B**	120	Osage Beach
Pontillas, Job B	174	Perryville
Previti, Vincent	082	Springfield
Pruett, Don S	190	St. Louis
Radford, Diane M	190	St. Louis
Rao, Ricardo	190	Chesterfield
Reardon, Thomas M	050	N. Kansas City
Reese, Jon A	082	Springfield
Reister, Philip D	125	Kansas City
Rendleman, George F, Jr.	190	St. Louis
Richards, Frank O	190	St. Louis
Richardson, Donna T	074	Union
Richardson, Norbert L	074	Union
Richmond, Ron	042	Cape Girardeau
Riechers, Thomas B	074	Washington
Roberts, Jonathan M	058	Jefferson City
Rodriguez, Gregorio L	202	Charleston
Rodriguez, Ubaldo R	190	St. Louis
Rogers, Jerry B	082	Springfield
Roh, Joseph J	125	Kansas City
Rosenbloom, Michael	190	St. Louis
Rubin, Brian G	002	St. Louis
Runez, Manuel W	158	Maryville
Safley, Thomas J	125	Independence
Schaefer, Glennon S	190	St. Louis
Schlarman, David E	190	St. Louis
Schneider, Thomas A	189	St. Charles
Schuh, Marlys E	190	Creve Coeur
Scott, Joni C	082	Springfield
Sharlow, Joseph W	174	Ste. Genevieve
Shine, Thomas E	190	St. Louis
Shoults, Nicholas F	082	Springfield
Sicard, Gregorio A	190	St. Louis
Snyder, Charles L	125	Overland Park, KS
Spadone, Donald P	026	Columbia
Standiford, Steven B	026	Columbia
Steiling, Sylvia A	190	St. Louis
Steinberg, John B	082	Springfield
Strasberg, Steven M	190	St. Louis
Sugarbaker, Stephen P	058	Jefferson City
Switzner, Diane L	082	Springfield
Tang, Teodoro	135	Salem
Tenorio, Arturo A	158	Stanberry
Terry, Boyd E	026	Columbia
Thiele, Otto K	189	St. Charles
Thornton, Fred H	202	Sikeston
Trinidad, Hermanito R	078	Chillicothe
Troop, Bryan R	190	St. Louis
Tucker, George L	190	Chesterfield
Turner, William A	214	Nevada
Underwood, Johnson, III	050	N. Kansas City
Verzola, Eufemio G	106	Herculaneum
Vidals, Victor G	125	Kansas City
Viloria, Alberto B	190	St. Louis
Vitale, Thomas J, Jr.	190	St. Louis
Wade, Scott A	030	St. Joseph
Wadley, John J	178	Sedalia
Waldschmidt, Mike L	125	Liberty
Waltz, James R	050	Liberty
Webb, John M	050	Kansas City
Wells, Samuel A, Jr.	190	St. Louis
Werner, F. Scott	050	N. Kansas City
Westerman, Robert N	190	St. Louis
Westfall, Scott G	190	Chesterfield
Westfall, Susan H	190	Chesterfield
Wetzel, C. Robert	086	Clinton
Wetzel, Gus S	086	Clinton
Willcoxon, Robert L	102	Joplin
Windmiller, M. Eugene	026	Columbia
Wittmer, Marc R	082	Springfield
Wonder, Donald	208	Branson
Woods, John J, Jr.	190	St. Louis
Yap, Mardonio J	190	Florissant
Yates, William D	190	St. Louis
Zacharias, Kulangara P	026	Columbia

Gynecology (GYN)

Alderman, Lillian C	050	Liberty
Ferneau, James E	026	Columbia
Jacob, Joe	026	Columbia
Patterson, Donald C	026	Columbia
Roberts, Howard H	102	Joplin
Schmidt, Herbert J	102	Joplin
Watson, Trevor F	026	Columbia
Williams, Carol F	190	St. Louis

Hematology (HEM)

Abbey, Elliot E	002	St. Louis
Bayer, William L	125	Kansas City
Carden, Juan O	190	St. Louis
Carter, Robert L	102	Joplin
Chan, Celia L	042	Cape Girardeau
Davidner, Mark L	125	Kansas City
Gomez, Patrick L	082	Springfield
Grant, Ruth	082	Springfield
Loftus, Loretta S	125	Kansas City
Minkoff, I. Monica	189	St. Peters
Monaghan, Greg G	026	Columbia
Muscato, Joseph J	026	Columbia

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Muscato, Mary S	026	Columbia
Peterson, Jay T	125	Kansas City
Ratkin, Gary A	190	St. Louis
Vellek, Mark J	026	Columbia
Weigand, Robert T	030	St. Joseph
Woodson, Mark E	190	St. Louis

Head & Neck Surgery (HNS)

Seabaugh, Janice L	042	Cape Girardeau
Wyrsch, Robert B	082	Springfield

Infectious Diseases (ID)

Brewer, Joseph H	125	Kansas City
Driks, Michael R	125	Kansas City
Fried, John S	125	Overland Park, KS
Haddow, Alastair D	082	Springfield
Henry, R. Beth	125	Kansas City
Hinrichs, James H	190	Bridgeton
McKinsey, David S	125	Kansas City
Neihart, Robert E	125	Kansas City
Smith, David Lambuth	125	Kansas City
Spernoga, John F	190	St. Louis
Winton, Mark D	058	Jefferson City

Internal Medicine (IM)

Abel, Charles C	190	St. Louis
Abinoja, Conrado B	190	St. Louis
Aguinaldo, Jaime A	190	St. Louis
Ahadi, Abd U	190	St. Louis
Ahern, Archibald M	190	St. Louis
Ahmad, Musaddeque	138	Potosi
Ahmad, Naseer	190	St. Louis
Albano, Grace A	125	Independence
Alegre, Jorge M	190	Chesterfield
Allen, Thomas P	125	Overland Park, KS
Allyn, Steven L	082	Springfield
Alonso-Yague, Pascual	190	Florissant
Alvarez, Ulises C	190	Florissant
Andrews, Paul E	082	Springfield
Anslinger, David L	190	Chesterfield
Assi, Nizar A	190	Chesterfield
Atwood, Steven D	082	Springfield
Avioli, Louis V	190	St. Louis
Aydt, Sarah A	042	Cape Girardeau
Azan, Kenneth N	178	Sedalia
Back, Donald K	082	Springfield
Backstrom, Jay T	125	Kansas City
Baker, Tim E	074	Washington
Balakrishnan, Roja	135	Rolla
***Balcer, Conrad S**	058	Jefferson City
Banton, M. Roman	190	St. Louis
Barjenbruch, Peggy W	014	Mexico
Barlow, Val John	190	Chesterfield
Barnes, Larry G	166	Neosho
***Barnum, Grant M**	120	Osage Beach
Barrido, Lemuel T	138	Potosi
Barrow, Jack	190	St. Louis
Bartell, Michael F	190	St. Louis
Bateman, Timothy M	125	Kansas City
Bauer, Daniel J	190	St. Louis
Bautz, James B	125	Kansas City
Bauwens, Daniel B	190	Chesterfield
Beato, David L	190	St. Louis
Benedict, William W	190	Chesterfield
Bentley, John D	082	Springfield
Berdy, Susan S	190	St. Louis
Berkowitz, Ellis R	030	St. Joseph
Bernabe, Ofelia M	190	St. Louis
Bernstein, Aaron M	190	St. Louis
Best, John A	190	Chesterfield
Bettonville, Peter V	190	St. Louis
Betz, Richard J	166	Neosho
Biggs, Alfred D, Jr.	125	Kansas City
Birge, Clifford A	190	St. Louis
Blum, Donald A	190	St. Louis
Boldt, Thomas H	190	Bridgeton
Bonsanti, Robert L	190	Bridgeton
Boonshaft, Benje	190	St. Louis
Borja, Egbert R	082	Springfield
Borowsky, Benj A	190	St. Louis
Borrego, Raul A	138	Farmington
Bowe, Christopher C	190	St. Louis
Bowles, G R	190	St. Louis
Bownik, Theodore B	050	Kansas City
Boyer, Peter A	058	Jefferson City
Bregant, Robert E	058	Jefferson City
Breite, Warren M	106	Festus
Brinkman, Robert A	190	Chesterfield
Broaddus, Loren E	082	Springfield
Brockman, M. Douglas	082	Springfield
***Brocksmith, James T**	026	Columbia
Brody, Arnold G	190	St. Louis
Broun, Goronwy O, Jr.	190	St. Louis
Brown, Barry D	190	St. Louis
Bryant, T J	125	Kansas City
Budd, John J, Jr.	190	St. Louis
Burmeister, R. William	190	St. Louis
Burns, Edward L	190	St. Louis
Burns, Thomas W	026	Columbia
Burris-Velloff, Tara M	125	Prairie Village, KS
Butin, Richard E	125	Kansas City
Butsch, Richard H	190	St. Peters
Cabral, Galileu	190	Florissant
Caldwell, Fred M	034	Poplar Bluff
Camp, Alan D	002	Bridgeton
Campbell, J. William	190	St. Louis
Cannistraro, Rosemary L	190	St. Louis
Carmody, John P	190	St. Louis
Cary, John M	190	Chesterfield
Cavero, Fernando L	066	Bolivar
Chandra, Mahesh	125	Independence
Chandramohan, Nanjappa	102	Carthage
Chase, Larry K	082	Springfield
Chern, Mou S	206	Ava
Chernoff, Selbert G	125	Lee's Summit
Chin, Mark Maw-Chang	190	Chesterfield
Chouinard, Michael P	202	Sikeston
Clark, David P	026	Columbia
Clark, Robert C	030	St. Joseph
Coates, James G	002	St. Louis
Cochran, Thomas E	082	Springfield
***Cohen, Donald L**	125	Kansas City
Cohen, Faye C	190	Chesterfield
Cohen, Hillard K	190	St. Ann
Convery, Paul B	190	St. Louis
Cooper, Barry J	190	St. Louis
Copp, Ralph	190	St. Louis
Coppinger, Thomas A	125	Kansas City
Corder, James C	190	St. Louis
Cramer, Quentin	125	Kansas City
Crespin, Stephen R	190	St. Louis
Crie, J. Stanley	030	St. Joseph
Crockett-Maples, Melinda	082	Springfield
Cruz, Sergio G	166	Monett
Cryer, Philip E	190	St. Louis
Cuddihee, Robert E	190	St. Louis
Cummings, Steven W	190	Brentwood
Cunningham, Edwin J	190	Chesterfield
Cunningham, Richard D	082	Springfield
Curry, Michael J	189	St. Charles
Custer, Galen M	125	Overland Park, KS
***Daly, Michael M**	026	Columbia
Dames, Richard J	190	Chesterfield
Daniels, John S	002	St. Louis
Deckard, Shelby W	082	Springfield

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INTERNAL MEDICINE

DeFeo, Frederick G	125	Kansas City
Delcambre, Marie A	125	Kansas City
Dembinski, David R	125	Kansas City
Dew, Thomas A	190	Chesterfield
Dexter, J. Kent	082	Springfield
Diestelhorst, James A	190	St. Louis
Dieterle, Brian D	208	Branson
DiPasco, Donald J	190	St. Louis
Dorton, Robert K	190	St. Louis
Dorzab, Linda L	125	Overland Park, KS
Dotson, Lori J	026	Boonville
Duff, James E	082	Springfield
Duff, John A	082	Springfield
DuMonteer, Gary	074	Washington
Dye, Jennifer A	082	Springfield
Emerson, William A	190	St. Louis
Emons, Matthew F	190	Louisville, KY
Enriquez, Roman S	125	Kansas City
*Entrup, Mark H	082	Springfield
Ervin, John E	125	Kansas City
Esguerra, Eden M	102	Joplin
Ethirajan, Sukumar	125	Kansas City
Evans, Andrew L	082	Springfield
Farnham, Milo M	125	Independence
Farrell, Thomas M	002	St. Louis
Faruqi, Sohaib A	138	Potosi
Favors, Adolphus C, Jr.	190	St. Louis
Fedor, Barbara A	082	Springfield
Ferguson, John L	082	Springfield
Ferrara, Robert P	190	St. Louis
Figueroa, Eliseo O	190	St. Louis
Fischer, Robert	190	St. Louis
Fishman, Norman	190	Chesterfield
Fitch, Coy D	190	St. Louis
Fleming, David A	046	Moberly
Fleming, J. Will , Jr	046	Moberly
Flicker, Michele R	125	Kansas City
Flotte, Sylvester A	190	St. Louis
Flury, Kirk E	190	St. Louis
Fogarty, William M, Jr.	190	St. Louis
*Frank, Robert A	125	Independence
Fraser, Victoria J	190	St. Louis
Frey, Jeffrey P	026	Columbia
Froehlich, Thomas W	082	Springfield
Galant, Mark R	125	Belton
Galbreath, Ashford M, Jr.	125	Kansas City
Gale, Arthur H	190	St. Louis
Galvez, Sisenando P	078	Marceline
Garcia, Kathleen M	190	St. Louis
Garfinkel, Bernard T	190	St. Louis
Garriga, Francisco J	190	Florissant
Gatchalian, Felicitas Z	190	St. Louis
Gedney, William B	190	Valley Park
Geier, David L	082	Springfield
Gendel, Jonathan	125	Lee's Summit
Gentsch, Kenneth W	190	St. Louis
Ghazal-Albar, Naman	150	Louisiana
Ghosh, Nellie	190	St. Louis
Gill, Paul J	082	Springfield
Gillbanks, Marjon M	125	Independence
Ginardi, Donald E	125	Kansas City
Ginther, James W, Jr.	190	St. Louis
Giorgi, Lee V	125	Kansas City
Glazer, Melvin L	125	Kansas City
Godwin, Lehman W	082	Springfield
Goldman, Arnold M	190	St. Louis
Goldman, Barry C	125	Kansas City
Goodenberger, Daniel M	002	St. Louis
Goodwin, J. Wendall	082	Springfield
Gordon, Mark E	050	N. Kansas City
Gould, Ronald J	190	St. Louis
Grady, Ronald K	190	Chesterfield
*Graessle, Donna M	125	Kansas City
Grant, John M	190	St. Louis
Grant, Neville	190	St. Louis
Gray, Gary J	190	St. Louis
Greenlaw, Cal W	078	Chillicothe
Greenwald, James E	190	St. Louis
Gregory, Mark H	190	St. Louis
Griesbaum, Robert V	190	St. Louis
Gutierrez, Anthony C	125	Kansas City
Gutierrez, Ernesto	190	Florissant
Guyol, William B, Jr.	190	St. Louis
Gwin, Edward	082	Springfield
Hagemann, Margarethe H	190	St. Louis
Hagen, Garrett A	190	St. Louis
Hale, Thomas H	190	Manchester
Hall, Deborah M	125	Overland Park, KS
Halloran, Mark J	190	St. Louis
Halpin, Stephen E	150	Hannibal
Halsted, Robert W	074	Washington
Halsted, Teresa M	074	Washington
Hamburg, Eric D	138	Farmington
Hamid, Zahid	158	Mound City
Hammerman, Marc R	190	St. Louis
*Handlin, Larry R	014	Mexico
Hardy, Patrick J	190	Florissant
Hardy, Samuel W	190	St. Louis
*Harris, William D	125	Lenexa, KS
Hawatmeh, Isam	190	St. Louis
Heins, James N	190	St. Louis
Hellam, Duane C	082	Springfield
Herfkens, Kenneth D	082	Springfield
Hernandez, Richard P	138	Cape Girardeau
Hill, M. Robert	190	St. Louis
Himes, Joyce B	082	Springfield
Hintze, Paul F	190	Chesterfield
Hoeman, Michael D	082	Springfield
Hoeper, Samuel D, Jr.	125	Kansas City
Hoffman, Leanna M	078	Hamilton
Hoffmann, Sandra S	190	Chesterfield
Hogan, Cornelius E	190	St. Louis
Hogan, John R	190	St. Louis
Hoover, Bernard L	190	St. Louis
Horine, Jon A	125	Kansas City
Hu, Raymond J	189	St. Peters
Huck, Richard F, Jr.	190	St. Louis
Husted, Frederick C	082	Springfield
Hyatt, Robert W	058	Jefferson City
Inman, Max M	190	Chesterfield
Irvin, William S	026	Columbia
Jackson, Dorothy J	125	Gladstone
Jafri, Syed F	078	Hamilton
Jain, Poonam M	190	St. Louis
Jain, Sangeeta	058	Jefferson City
Jantz, Keith	125	Kansas City
Jarvis, Cathy C	190	Florissant
Javdan, Ron	190	St. Louis
Jayamanne, Damasus S	058	Jefferson City
Jedlinski, Michael T	042	Cape Girardeau
Johnson, Eric J	002	Chesterfield
Johnson, Warford B, II	082	Springfield
Joseph, Harold J	190	St. Louis
Jotte, Richard P	190	St. Ann
*Joubert, Paul M	125	Lee's Summit
Juergens, William G	190	St. Louis
Kanagawa, Harold K	058	Jefferson City
Kantor, Owen	190	St. Louis
Kardesch, Milton	190	St. Louis
Karsh, Robert S	190	St. Louis
Kaufman, Robert L	190	St. Louis
Kauk, Bruce A	050	N. Kansas City
Kaup, Chandra S	190	Florissant
Keairnes, Harold W	125	Kansas City
Kelly, John J	190	St. Louis
Kerkemeyer, George	150	Hannibal
Khalil, Tamer G	082	Springfield
Kichura, George M	190	St. Louis

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*Doctor of Osteopathy

Kiehl, Mary M	190	St. Louis
Kim, Chul	034	Poplar Bluff
King, Donald K	190	St. Louis
Kinsella, Peter W	190	St. Louis
Kipnis, David M	190	St. Louis
***Kirila, Carol E**	030	St. Joseph
Kirkland, Jerry A	050	Kansas City
Kissell, Richard W	082	Springfield
Klachko, David M	026	Columbia
Klearman, Micki	190	St. Louis
Knight, William A, Jr.	190	St. Louis
Knowlton, Norman P, III	082	Springfield
Kohler, Roy	082	Springfield
Kolb, Lisa G	058	Jefferson City
Kopp, Kenneth R	125	Lenexa, KS
Krewet, Frank A, III	190	St. Louis
Kriegshauser, James W	190	St. Louis
Kuangparichat, Manoch	118	Excelsior Springs
Kuhlman, Ralph F	190	St. Louis
Kunst, Edward J	190	Ballwin
Laird, John M	190	St. Louis
LaMonda, Gary W	026	Columbia
Landau, David W	190	St. Louis
Landman, Danielle	002	St. Louis
Landsbaum, Charles J	058	Jefferson City
Lankachandra, Bharata	010	Savannah
LaPietra, Martha M	125	Kansas City
Latif, Azhar	118	Lexington
Lauer, Danl J	125	Overland Park, KS
***Lawson, Gina E**	002	Smithville
Leeper, Sidlee W	026	Rocheport
Lehman, Robert B	190	St. Louis
Leightner, William F	190	St. Louis
Leitch, Steven M	082	Springfield
Letizia, Wayne L	125	Independence
Levy, Morton A	190	St. Louis
Lewandowski, Molly J	125	Leawood, KS
Lieberman, David M	190	St. Louis
Lila, Aram	050	Excelsior Springs
Lilly, Douglas R	190	St. Louis
Lin, H T	046	Moberly
Lindeman, John F	190	Chesterfield
Little, Blake A	102	Joplin
Lockard, Orlyn O	030	St. Joseph
Loeb, Richard H	082	Springfield
Loeffler, Roberta L	190	St. Louis
Loeppky, Carol B	026	Columbia
Loggan, Michael B	050	Liberty
Long, Priscilla E	150	Hannibal
Loomis, James F	190	St. Louis
Lovinger, Warren C, Jr.	214	Nevada
Lyons, Daniel F	082	Springfield
Lyss, Carl A	190	St. Louis
Maben, Sam E	125	Kansas City
Mack, Marvin L	026	Columbia
Macleod, Angus	190	St. Louis
MacGorman, Linda R	082	Springfield
Majors, Patrick F	190	St. Louis
Mallouk, Alexander G	125	Kansas City
Mantell, Jack M	082	Springfield
Margolis, David M	190	St. Louis
Martin, Chris J	026	Columbia
Mass, Joan H	190	St. Louis
Mathews, Jeffrey E	190	St. Louis
Mayus, Joseph L	082	Springfield
McCarthy, Christopher	190	St. Louis
McCool, James F	190	St. Louis
McCormack, Robert E	125	Kansas City
McDonald, James H	125	Kansas City
McDonald, Wallace	030	St. Joseph
McGovney, Janice K	050	Kansas City
McKeel, Thomas B	125	Kansas City
McLemore, Willie O	125	Kansas City
McMillan, David L	166	Neosho
McMillen, James J	030	St. Joseph
***McNabb, M. Jeffery**	042	Cape Girardeau
Mehra, Ravi	190	St. Louis
Meidl, Erik J	150	Hannibal
Mejia, Victor E	202	Sikeston
Meldi, Dominic M	082	Springfield
Meltz, Gary J	189	St. Charles
Mendelsohn, Robert S	190	St. Louis
Metry, Donald J, Jr.	078	Chillicothe
Mihalevich, John A, Jr	082	Springfield
Miles, Richard W	102	Joplin
Miller, Dace L	082	Springfield
Miller, Donald	058	Jefferson City
Mills, Melissa J	002	Overland Park, KS
Minnigerode, Turner L	125	Kansas City
Miskovsky, Emil F	190	St. Louis
Mitchell, Lynn D	026	Columbia
Mitchem, Randall E	058	Jefferson City
Mohs, Frank R	190	St. Louis
Molden, C. Scott	190	St. Louis
Monaco, Michael	125	Harrisonville
Montgomery, Austin F	190	St. Louis
Moore, John M	125	Kansas City
Morgan, Vincent I	054	Cameron
Moriconi, William J	190	St. Louis
Morris, J H	125	Independence
Morton, David J	190	St. Louis
Motchan, Dennis G	190	Bridgeton
Muegge, F. David	082	Springfield
Muhammud, Faquir	190	St. Louis
Mullen, Mary E	014	Mexico
Mullican, Charles N	030	St. Joseph
Mullins, John E	190	Chesterfield
Nanson, Duane	026	Columbia
Narayan, Dilip L	190	Chesterfield
Narkiewicz, Lawrence S	190	St. Louis
Nelson, Donald C	082	Springfield
Nelson, J. Roger	190	St. Louis
Nguyen, Khanh X	002	Kansas City, KS
Nicholas, Stephen P	190	St. Louis
Nickell, Michael D	102	Joplin
Niesen, Anna R	190	St. Louis
Nix, J. Gustavo	066	Bolivar
Norland, Charles C	190	St. Louis
Novack, Mark A	190	Chesterfield
Nulton, Carnie C	125	Kansas City
Nyazee, Muhammad A	190	Bridgeton
Nye, Terry R	082	Springfield
Ockner, Samuel A	190	Chesterfield
O'Connor, Mary C	125	Kansas City
O'Donnell, Susan M	174	Ste. Genevieve
O'Keefe, James H, Jr.	125	Kansas City
Olsen, Teresa A	082	Springfield
Olson, James H	050	Liberty
Orgel, S. Michael	190	St. Louis
Orlando, Louis A	125	Kansas City, KS
Ortbals, David W	190	Chesterfield
O'Toole, Lisa	125	Overland Park, KS
Ovens, Lisa	082	Springfield
Owen, Robert F	190	St. Louis
Packman, Robert C	190	St. Louis
Palazola, Joseph M	125	Kansas City
Paletta, Frank	190	St. Louis
Paletta, Victor L	190	Bridgeton
Paone, Douglas B	125	Kansas City
Park, Duk J	106	Festus
Parks, Deborah L	190	St. Louis
Patel, Indu B	106	Barnhart
Peck, William A	190	St. Louis
Pereira, MaryBeth	190	St. Louis
Perez, Robert J	190	St. Louis
Perll, Michael F	125	Kansas City
Perryman, J. Chris	125	Kansas City
Pfefer, Leland U	026	Columbia

Specialty Roster (as of 7/29/96)

*Doctor of Osteopathy

Pfefferkorn, David A	202	Sikeston
Phillips, William J	190	Chesterfield
Pickering, Lee I	125	Independence
Piening, Kurt A	189	St. Charles
Pierce, Dan L	026	Columbia
Pineda, Hector O	190	St. Louis
Pitts, Olevia	125	Overland Park, KS
Podolsky, Howard S	002	St. Louis
Pogson, George W, III	125	Independence
Ponstingl, Raana J	190	St. Louis
Postma, George S, Jr.	125	Mission, KS
Potts, Dan E	190	Chesterfield
Powell, Kenneth R	082	Springfield
Prelutsky, David J	190	St. Louis
Proskey, Vincent J	190	Chesterfield
Purcell, Henry E	190	St. Louis
Purcell, Richard D	082	Springfield
Puro, Edward A	190	Florissant
Pyszczynski, Dennis R	125	Kansas City
Qureshi, Abdul R	190	St. Louis
Rabang, Lazaro U	078	Bethany
Raju, Niranjana	174	Ste. Genevieve
Ramirez, Samuel G	190	St. Louis
Ramsey, Robert H	190	Florissant
Randolph, Kerry A	082	Springfield
Ranginani, Anil K	010	Savannah
Rangineni, Rajagopal	030	St. Joseph
***Rankin, W. Dale**	102	Joplin
Rau, Michael E	074	Washington
Raybould, Michael W	125	Kansas City
Razzaq, A.	190	St. Louis
Rearden, Timothy P	190	St. Louis
Reardon, Thomas F	190	St. Louis
Redington, James C, Jr.	190	St. Louis
Redmon, Conchita M	082	Springfield
Reeder, Stephen M	082	Springfield
Reh, Edward P, Jr.	190	St. Louis
Reynolds, James A	190	Chesterfield
Rice, Karen H	058	Jefferson City
Richards, Dean D, III	125	Kansas City
Riley, Joel Y	002	St. Louis
Riojas, Lisa A	135	Rolla
Rippe, William F	030	St. Joseph
Ritter, C J	042	Cape Girardeau
Robinson, Nicholas F	070	Kennett
Robinson, Ronald L	042	Cape Girardeau
Rogers, James T	082	Springfield
Romaker, Ann M	125	Kansas City
Rosecan, Marvin	190	Belleville, IL
Rosen, Larry A	125	Independence
Rosenberg, David S	190	Florissant
Rouse, Ernest T, III	190	St. Louis
Roxas, Generoso P	189	St. Charles
Russell, John J	042	Cape Girardeau
Salibi, Habbouba	190	Chesterfield
Samet, John M	190	St. Louis
Samuel, George P	034	Doniphan
Sandiford, Patrick	189	St. Charles
Sanfelippo, John F	058	Jefferson City
Sarma, Anuradha H	125	Lee's Summit
Schell, James A	026	Columbia
Scheperle, Mark A	190	St. Louis
Scherer, Stephen	125	Kansas City
Schierman, William D	190	St. Louis
Schmid, Tania L	190	St. Louis
Schmidt, Edwin H, III	190	St. Louis
Schnarr, William	189	St. Charles
Schneider, Paul G	190	St. Louis
Schneider, Robert J	190	St. Louis
Schondelmeyer, R. Wade	026	Columbia
Schuessler, Wolfgang P	190	St. Louis
Schuetz, Alfred	189	St. Charles
Schultz, Irwin	190	St. Louis
***Schwarze, Martin W**	190	St. Louis
Scott, C. Alan	198	Marshall
Scott, Michael R	082	Springfield
Scott, Robert W	082	Springfield
Sertl, James F	190	St. Louis
Shah, Riaz H	014	Mexico
Shalet, Malcolm F	125	Kansas City
Shapleigh, John B, II	002	Chesterfield
Shatz, Burton A	190	St. Louis
Shen, Anthony S	190	St. Louis
Shniter, Lorinna	190	St. Louis
Shuttari, Mir F	190	St. Louis
Sides, Stanley D	042	Cape Girardeau
Sindhwani,Ravinder(Ravi) K	150	Louisiana
Singh, Kuldeep	046	Macon
Singleton, Charles M, II	125	Kansas City
Singleton, John M, III	125	Kansas City
Sislen, Donald R	190	St. Louis
Sly, Anne K	125	Kansas City
Smalling, Ronnie G	082	Springfield
Smith, Kenneth B	074	Washington
Smith, Timothy W	125	Kansas City
Smoller, Martin B	189	St. Louis
Sneid, David S	125	Kansas City
Sollars, Eric G	030	St. Joseph
Sommer, Rand W	002	St. Louis
Soonattrakul, Wuthisak	070	Kennett
Sosna, Jacob P	190	St. Louis
Soucy, John C	189	St. Charles
Spaedy, Tony	026	Columbia
Spinzig, Bruce D	046	Moberly
Spivack, Alan R	190	Chesterfield
Sprague, Gita	030	St. Joseph
Spurgat, Robert M	030	St. Joseph
Squitieri, Alphonse J	190	St. Louis
Stansfield, Julie D	026	Columbia
Starke, Keith M	190	St. Louis
***Steinbrecher, Janis M**	125	Lee's Summit
Sterkel, Barbara B	190	St. Louis
Sterkel, Richard L	190	St. Louis
Stewart, James L	050	Weatherby Lake
Stiene, Henry A	102	Joplin
Strauss, Carl F	125	Kansas City
Stuber, Robert R	030	St. Joseph
Stufflebam, Robert E	082	Springfield
Suarez-Solar, Pedro L, Jr.	190	St. Louis
Subramanian, S.	102	Carthage
Sullivan, William W	190	St. Louis
Suwannasri, Rudee	190	St. Louis
Swaykus, Bernard T	190	Bridgeton
Sylvanovich, W. Richard	190	St. Louis
Tanphaichitr, Kongsak	190	St. Louis
Tansuwan, Chukiat	190	St. Louis
Tariq, Manzoor A	190	Chesterfield
Taylor, William K	082	Springfield
Tepper, Arnold	190	St. Louis
Thesing, John A	125	Lenexa, KS
Threlkeld, Kevin L	002	Lake St. Louis
Tilson-Mallett, Nancy R	125	Kansas City
Titterington, Frank W	125	Kansas City
Torontow, R. John	214	Nevada
Toubes, Daniel B	125	Kansas City
Trentham, Orin P, III	102	Joplin
Troeh, Melvin R	125	Independence
Trotter, W. Yates	082	Springfield
Trygg, Kelly A	066	Bolivar
Tucker, Leslie E	074	Washington
Uchiyama, Robert C	190	Chesterfield
Uhrig, Jack R	198	Marshall
***Vale, Janett A**	125	Kansas City
VanGoidsenhoven, Guy E	190	St. Louis
Van Voorn, Catherine M	026	Columbia
Varma, Devendra K	034	Poplar Bluff
Vazquez, Jose L	002	Florissant
***Venter, John L**	102	Joplin

*Doctor of Osteopathy

Ver Dught, Ammon L	125	Independence
Vibulakaopun, Pairat	138	Bonne Terre
***Vogelsang, Judith K**	125	Kansas City
Vournas, George C	190	Bridgeton
Wade, Kim C	125	Kansas City
Wagan, Primitiva C	190	St. Louis
Waheed, Shahid	014	Mexico
Wald, Stanley M	190	St. Louis
Walden, James M	125	Kansas City
Walker, Harvey , Jr.	190	St. Louis
Walsh, James W	190	St. Louis
Wantuck, Donald K	082	Springfield
Webb, Karen B	190	St. Louis
Weinstock, Leonard B	190	St. Louis
Weiss, Peter D	190	St. Louis
Welsh, Thomas E, III	014	Mexico
Welton, Stephen T	202	Sikeston
Wenneker, Alvin S	190	St. Louis
Westhoff, David D	058	Jefferson City
Wethers, Darren E	002	St. Louis
Weyerich, Noel F	190	St. Louis
Whitman, Daniel S	125	Kansas City
Whittaker, Thomas J	125	Kansas City
Wilkins, Michael S	125	Kansas City
Williams, R. Jerome , Jr.	190	St. Louis
Wilt, David A	125	Kansas City
Winer, Nathaniel	125	Kansas City
Wolfe, John E	082	Springfield
Wolff, Gerald A	190	St. Louis
Woolery, William G	178	Sedalia
Wright, Jeffrey M	190	St. Louis
***Wright, Robert A**	190	St. Louis
Wright, William P	190	St. Louis
Wuellner, David H	178	Sedalia
Wurster, Mark W	125	Kansas City
Yoxall, Kelly E	125	Kansas City
Yu, Simon M	190	St. Louis
Zerr, Charles H	125	Independence
Zimmerman, Herbert B	190	St. Louis
Zylka, J. Michael	190	St. Louis

Maternal & Fetal Medicine (MFM)

Dix, Patricia M	082	Springfield
Sunderji, Shiraz	190	St. Louis

Neonatal-Perinatal Medicine (NPM)

Braun, William J	125	Kansas City
Pettett, Gary	125	Kansas City
Slack, Melinda R	082	Springfield
Thibeault, Donald W	125	Kansas City

Nephrology (NEP)

Benson, Larry E	050	N. Kansas City
Birenboim, Nancy	125	Kansas City
Braxton, Frank W	042	Cape Girardeau
DeFranco, Penny E	190	Bangor, PA
Dobyan, Dennis C	030	St. Joseph
Langley, Harriet S	125	Kansas City
Mir, A. Rauf	125	Kansas City
Redington, James C	050	N. Kansas City
Sivarajan, Subramanian	125	Kansas City
Thomas, Alexis G	125	Kansas City
Winkelmeyer, William K	026	Columbia

Neurology (N)

Abrams, Bernard M	125	Kansas City
Adelmann, Eugene	190	St. Louis
Allen, Arthur A, II	125	Shawnee Mission, KS
Andrew, Christopher R	102	Joplin
Applegate, Clara	206	West Plains
Arkin, Steven M	125	Kansas City
Arora, Ravinder S	178	Sedalia
Asher, Irving M	026	Columbia
Awadalla, Sylvia	190	St. Louis
Batchu, Sudhir S	026	Columbia
***Belson, Ian L**	125	Kansas City
Bettinger, Irene E	125	Kansas City
Bhothinard, Bhisit	034	Poplar Bluff
Bonner, James S	190	St. Louis
***Brown, Carl D**	148	Kirksville
Brownsworth, Ronnie D	082	Springfield
Choi, Dennis W	190	St. Louis
Chou, Wesley H	002	Overland Park, KS
Davuluri, Sreenadha R	030	St. Joseph
Dean, Philip D	074	Washington
Desio, Marcus A	102	Joplin
Dexter, James D	026	Columbia
Dysart, Dorsey W, Jr	082	Springfield
Epstein, Beverly	166	Mt. Vernon
Gamboa, Edgardo C	030	St. Joseph
Geller, Bruce D	125	Kansas City
Hackett, Earl R	082	Springfield
Hanaway, Joseph	190	St. Louis
Hatlelid, J. Michael	190	St. Louis
Hoffmann, Lee M	125	Shawnee Mission, KS
Hogan, Patrick A	190	St. Louis
Hooshmand, Ahmad	058	Jefferson City
Horenstein, Simon	190	St. Louis
***Hosley, Brett D**	150	Hannibal
Lee, David Y S	042	Cape Girardeau
Legarda, Maria M	125	Kansas City
Lin, Chi-Hsi	082	Springfield
Luzecky, Michael H	082	Springfield
Makos, Mignon M	030	St. Joseph
Matovich, Violet B	125	Kansas City
McLaren, David L	026	Columbia
***Mellies, Steven D**	042	Cape Girardeau
Myers, Gary H	190	Chesterfield
Pentella, Karen J	190	St. Louis
Phillips, Daniel	190	St. Louis
Quinn, Rodney D	082	Springfield
Reiss, Jeanne E	125	Kansas City
Robinson, Jay G	125	Kansas City
Rosenbaum, Herbert E	190	St. Louis
Rymer, Marilyn M	125	Kansas City
Sahota, Pradeep K	026	Columbia
Schreiber, David J	190	Alton, IL
Schultz, Earl R	190	St. Louis
Selhorst, John B	190	St. Louis
Shakil, Mohammad	042	Cape Girardeau
Sher, Allyn L	026	Columbia
***Sherrod, Glenn M**	190	Bridgeton
Shuter, Eli	190	St. Louis
Simowitz, Fredric M	189	St. Charles
Sohn, Richard	190	St. Louis
***Stahly, Randall L**	042	Cape Girardeau
***Turpin, F. Duane**	190	Bridgeton
Weinstein, Charles L	125	Kansas City
Weiss, Howard	190	St. Louis
Weiss, Stuart	190	St. Louis
Winkler, Terry	082	Springfield
Wong, George F, III	082	Springfield
Yanover, Robert A	190	St. Charles
Yu, Mario K	125	Kansas City

Neurological Surgery (NS)

Albanna, Faisal J	190	St. Louis
Backer, Robert J	190	St. Louis
Bailey, Gregory J	190	St. Louis
Bernardi, Robert J	190	St. Louis
Blatt, Geoffrey L	125	Kansas City
Boland, Michael F	190	Chesterfield
Bondurant, Charles P	026	Columbia
Briggs, Thomas B	082	Springfield
Bucholz, Richard D	190	St. Louis

*Doctor of Osteopathy

Canlas, Mario P	**082**	Springfield
Chaudhari, A. Basit	**042**	Cape Girardeau
Cheung, K. Charles	**042**	Cape Girardeau
Chilton, Jonathan D	**125**	Kansas City
Colapinto, Edward V	**026**	Columbia
Cole, Harry O	**190**	Chesterfield
Cox, Curtis S	**058**	Jefferson City
Coxe, William S	**190**	St. Louis
Crabtree, H. Mark	**082**	Springfield
Crafts, David	**190**	St. Louis
Dacey, Ralph G, Jr.	**190**	St. Louis
Daus, Arthur Steven	**102**	Joplin
Ditmore, Q. Michael	**026**	Columbia
Dunn, Robert C, Jr.	**190**	St. Louis
Ferguson, John F	**082**	Springfield
Gold, Jonathan A	**190**	St. Louis
Goldring, Sidney	**190**	St. Louis
Greenberg, Jeffrey A	**102**	Joplin
Grubb, Robert L, Jr.	**190**	St. Louis
Hanson, E J	**125**	Kansas City
Hoffman, William F	**190**	St. Louis
Hornig, Gregory W	**125**	Kansas City
Jimenez, David F	**026**	Columbia
Kaufman, Andrew B	**125**	Kansas City
Kaufman, Bruce A	**190**	St. Louis
Kennedy, David G	**190**	St. Louis
Ketcherside, W. Joseph	**050**	N. Kansas City
Kim, Yong Kie	**042**	Cape Girardeau
Krettek, John E	**190**	Chesterfield
MacGee, Edwin E	**125**	Kansas City
Majzoub, Hish S	**102**	Joplin
Marchosky, J. Alex	**190**	Chesterfield
Martin, Stanley B	**190**	St. Charles
Mendelsohn, George E	**190**	Chesterfield
Mollman, H. Dennis	**190**	Chesterfield
Morantz, Robert A	**125**	Kansas City
Mujica, Patricio H	**030**	St. Joseph
Nichols, Margaret E	**102**	Joplin
Olson, John P	**030**	St. Joseph
Oro, John J	**026**	Columbia
Orth, O. Gerald	**026**	Columbia
Park, Bert E	**082**	Springfield
Park, Kee B	**042**	Cape Girardeau
Picker, Selwyn	**190**	St. Louis
Pittmann, Thomas	**190**	St. Louis
Reintjes, Stephen L	**125**	Kansas City
Rich, Keith M	**190**	St. Louis
***Routsong, Rodney T**	**190**	St. Louis
Schoolman, Arnold	**125**	Kansas City
Scodary, Daniel J	**190**	Bridgeton
Sheehan, Paul J	**190**	Bridgeton
Silbergeld, Daniel L	**190**	St. Louis
Smith, Edward B	**125**	Kansas City
Smith, Kenneth R, Jr.	**190**	St. Louis
Stohr, Paul E	**190**	St. Charles
Vollmer, Dennis G	**190**	San Antonio, TX
Walker, Francis S	**190**	St. Louis
Walker, Gregory E	**125**	Independence
Whitlock, C. Courtney	**082**	Springfield
Wilkinson, David	**190**	St. Louis
Yoon, Kong-Woo	**190**	St. Louis
Young, Paul H	**190**	St. Louis

Nuclear Medicine (NM)

Allego, Melquiadito M	**174**	Perryville
Egbert, Robert N	**082**	Springfield
Ho, Judith E	**190**	St. Louis
Long, Stephen E	**082**	Springfield
Siegel, Barry A	**190**	St. Louis

Nuclear Radiology (NR)

Hacker, Douglas A	**082**	Springfield

Obstetrics & Gynecology (OBG)

Adams, Kenneth A	**125**	Independence
Ahlering, Christopher L	**190**	St. Louis
Ahlering, George P	**190**	St. Louis
Ahlum, Sandra J	**150**	Hannibal
Ahmad, Nusrat J	**190**	Chesterfield
Anstey, John T	**190**	St. Ann
Appelbaum, John K	**002**	St. Louis
Bagwe, Lata R	**190**	St. Louis
Bale, Robert D	**190**	St. Louis
Batts, Barbara A	**125**	Kansas City
Beaty, William R	**190**	St. Ann
Becker, Robert L	**190**	St. Louis
Beckmann, Charles R.B.	**125**	Kansas City
Beguin, Everett A, Jr.	**082**	Springfield
Belew, Joe E	**190**	Chesterfield
Bell, Laird A	**082**	Springfield
Benitez, Jose A	**190**	St. Louis
Benson, Ronald G	**082**	Springfield
Benton, Mary Beth	**026**	Columbia
Bernabe, Florinio H	**190**	St. Louis
Black, William R	**102**	Joplin
Blaskiewicz, Robert J	**190**	St. Louis
Blythe, James G	**190**	St. Louis
***Boice, Brett E**	**102**	Joplin
Boice, Michelle A	**102**	Joplin
Bonebrake, Albert J	**082**	Springfield
Bonebrake, Mac D	**082**	Springfield
Bopp, J. Ronald	**102**	Seneca
Borello, Dan J	**102**	Joplin
Botney, Kathryn	**190**	Chesterfield
Boveri, Lawrence V	**002**	St. Louis
Boyd, Craig W	**190**	St. Louis
Braby, Howard H	**125**	Independence
Brennan, James M	**190**	St. Louis
Brennan, Robert A, Jr.	**190**	St. Louis
Brown, Cynthia L	**034**	Poplar Bluff
Brown, Robert J	**189**	St. Charles
Bruno, Patrick L	**150**	Hannibal
Burks, Michael L	**026**	Columbia
Burstein, Robert	**190**	St. Louis
Calbert, Cynthia C	**125**	Kansas City
Camejo, Manuel	**082**	Springfield
Cannon, Jenifer M	**002**	St. Louis
Cargill, Dianna L	**050**	Liberty
Casey, Arthur L	**190**	St. Louis
Cernik, Christine M	**190**	St. Louis
Chesney, John W	**102**	Joplin
Chirino, Octavio R	**190**	St. Louis
Chod, Ronald J	**190**	St. Louis
Clark, Larry K	**102**	Joplin
Clarke, Paul W	**042**	Cape Girardeau
Cohen, Robert S	**190**	St. Louis
Comas, Manuel R	**190**	St. Louis
Cooper, Robert L, II	**110**	Warrensburg
Coordes, Kathleen M	**190**	St. Louis
Corder, Robert L	**030**	St. Joseph
Cornwell, Karen R	**125**	Kansas City
Covarrubias, Jorge A	**190**	Collinsville, IL
Cox, Jeffrey L	**102**	Joplin
Coyne, Patrick M	**190**	Bridgeton
Crane, James P	**190**	St. Louis
Dagartzikas, A K	**190**	St. Louis
Dahm, Charles H, Jr.	**190**	St. Louis
Davidson, Raymond P	**190**	St. Louis
Del Pizzo, Ferdinand	**189**	St. Charles
Dement, Oman E	**102**	Joplin
DeUngria, Pablo C	**190**	Bridgeton
Dieterich, Russell B	**189**	St. Charles
Doan, Laura B	**125**	Raytown
Driskell, Karen K	**125**	Kansas City
Duncan, David T	**189**	Wentzville
Dunlap, Patrick S	**102**	Joplin

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Durel, Justin H	190	St. Louis
Eachempati, Uma R	190	Arnold
Eaton, Paula	125	Kansas City
Ekunno, Josiah O	190	St. Louis
Fast, Robert E	030	St. Joseph
Ferber, Alan J	125	Kansas City
Ferns, Francis E	125	Kansas City
Fleer, Gerald K	189	St. Peters
Fogle, Philip R	082	Springfield
Fortin, Jorge A	135	Rolla
Friesen, Randall G	189	St. Charles
Gall, Ira C	190	St. Louis
Gardner, Joe A	102	Joplin
Garrard, Jacqueline M	190	St. Louis
Garrison, David L	030	St. Joseph
Gay, John W	026	Columbia
Gimpelson, Richard J	190	Chesterfield
Goeking, C. Keith	030	St. Joseph
Goldman, Gordon M	190	St. Louis
Gonzalez-Pina, Roberto	202	Sikeston
Grace, Steve	082	Springfield
Grant, Laura L	026	Columbia
Grant, Mark	026	Columbia
Grebe, T. Keith	102	Joplin
Green, Thomas F	125	Independence
***Greenspan, Peter B**	125	Independence
Griffin, William T	026	Columbia
Grimm, Mary T	190	Florissant
Gulick, C. Richard	190	St. Louis
Gutknecht, Richard	125	Independence
Hahn, Yoram	190	Florissant
Halberstadt, Cathanie W	125	Kansas City
Handler, Michael R	190	St. Louis
Hanley, Thomas P	190	St. Louis
Hartman, Richard A	190	St. Louis
Haskins, Robert D, Jr.	082	Springfield
Hauser, Robert J	058	Jefferson City
Hayes, Kimberly W	125	Lee's Summit
Hazan, Joseph	190	Bridgeton
Heilman, M. Kathlyne	082	Springfield
Heller, Randall L, Jr.	190	St. Louis
Hickey, James L	190	St. Louis
Hill, Randy C	082	Springfield
Hoja, John M	034	Poplar Bluff
Hoja, W Alex	034	Poplar Bluff
Houck, William E	190	Chesterfield
Hubbell, George P	120	Osage Beach
Hulbert, Laura R	190	St. Louis
Hunleth, Frank E	190	St. Louis
Huse, William J, II	125	Kansas City
Huster, Robert M	135	Liberty
Ishida, Yasuo	190	St. Louis
Jantsch, Deborah A	125	Kansas City
Jessup, Michael J	042	Cape Girardeau
Jewell, Gregory L	002	St. Louis
Johar, Ravi S	190	St. Louis
Johnson, Joseph C, Jr	082	Springfield
Johnson, Rebecca S	125	Kansas City
Jones, Jeffrey T	102	Joplin
Jones, Michael D	014	Mexico
Kaigh, Jodi	135	Rolla
Kelly, John B	102	Joplin
Kim, Yang H	074	Washington
Kline, James	030	St. Joseph
Kobbermann, Kobby J	082	Springfield
Kraner, Justin F	190	St. Louis
Kratz, Donald P	082	Springfield
Kuebel, Richard J	190	St. Louis
Kumari, Vijaya	190	St. Louis
Kunda, Koteswara R	190	St. Louis
Lacey, Hugh L	102	Joplin
Ladd, Christine M	190	St. Louis
Lamping, J. Daniels	190	St. Louis
***Lentz, Rodney D**	058	Jefferson City
Levy, Edward S	002	St. Louis
Lin, C H	046	Moberly
Lintecum, Frederick B	125	Kansas City
Liu, Ben C	125	Kansas City
Llorens, Alfred S	026	Columbia
Lockwood, Gary F	125	Kansas City
Madduri, Aruna D	034	Poplar Bluff
Magaletta, George E	002	St. Louis
***Magill, William S**	082	Springfield
Maitz, Carlos A	190	St. Ann
Maminta-Streiff, Maria G	190	St. Louis
Mani, Mary E	190	Clayton
Marshall, William H	058	Jefferson City
Marston, F. James	030	St. Joseph
Martin, Daniel J	190	St. Louis
Mathew, Ruby	190	Chesterfield
Matile, Gerald U	125	Kansas City
Maupin, Kathy C	190	St. Louis
Maxson, Katherine A	190	Chesterfield
Maynard, Colleen M	125	Kansas City
McCorcle, Marcus D	082	Springfield
McDavid, Robert E	026	Columbia
McGuire, Thomas H	125	Overland Park, KS
McKeown, Robert A	206	Bucyrus
McLaughlin, Richard D	082	Springfield
Medler, John F	190	St. Louis
Meiners, Theodore M	190	Chesterfield
Middleton, Jerry N	190	Chesterfield
Miller, Gerald L, Jr.	125	Kansas City
Mistry, Tehmton S	190	Columbia, IL
Moeller, F. Delbert	189	Lake St. Louis
Monterubio, Fred R, Jr.	190	St. Louis
Montoya-Vinluan, Aurea C	125	Raytown
Mooney-Smith, Patricia	125	Kansas City
Moreton, David W	026	Columbia
Morley, Mary A	190	Chesterfield
Morris, Terry V	125	Independence
Mou, Susan M	125	Kansas City
Muckerman, Richard C, II	190	St. Louis
Mundy, David C	125	Kansas City
Murdock, Nathaniel	190	St. Louis
Nagy, Rickey E	125	Kansas City
Newport, Gerald	190	Florissant
Nickell, Margaret B	125	Kansas City
Ojascastro, Lou	190	St. Louis
Ong, Ofelia S	190	St. Louis
Ott, Harold J	190	St. Louis
Ott, William J	190	St. Louis
Otto, William J	082	Springfield
Padilla, Teresita C	190	Chesterfield
***Palmer, Allen S**	190	Bridgeton
Patty, Carl F	034	Poplar Bluff
***Patty, John R**	034	Poplar Bluff
Pearce, Eugene W. J.	125	Kansas City
Pearman, Carl C	002	Kansas City
Pearse, Carlton S	190	Chesterfield
Pearson, William E	190	St. Louis
Perryman, Douglas R	125	Kansas City
Phillips, Granville J	110	Warrensburg
Pignotti, Blase J	190	St. Louis
Poole, Anthony G	202	Sikeston
Potts, Gregory A	074	Washington
Powell, Lisa G	082	Springfield
Pringle, Scot G	042	Cape Girardeau
Pryor, Carolyn J	190	Florissant
Puckett, Lynn M	026	Columbia
Pyeatte, Jacob P, Jr.	042	Cape Girardeau
Rajcher, Wilma J	026	Columbia
Rappold, Henry O	190	Chesterfield
Redfern, David L	082	Springfield
Reed, Jonathan R	190	St. Louis
Rengachary, Dhanalakshmi	125	Kansas City
Rennard, Marvin	190	St. Louis
Rice, Lee Roy	102	Joplin

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Rice, Valerie M Kansas City, KS	050
Richardson, Curtis J St. Joseph	030
Ritter, Hubert A St. Louis	190
Roberts, Christopher H Joplin	102
Robinson, Gary L Springfield	082
Sachar, Jerome D St. Louis	190
Saha, Sudha R St. Louis	190
Schaberg, Kevin B Chesterfield	190
Schuetz, Evelyne G St. Charles	189
Schwartz, Howard I Kansas City	125
Seeck, Linda E Washington	074
Shaner, Thomas P St. Louis	190
Shelton, Becky R Chesterfield	190
Shroff, Kumkum St. Louis	190
Shultz, Thomas M Springfield	082
Siripipat, Pallop Mexico	014
Smiley, William L St. Louis	190
Smith, Brenda S Kansas City	125
Snidle, William F Crystal City	106
Snowden, Kent L St. Louis	190
Sopuch, John A St. Louis	190
Stamps, Gregory S Springfield	082
Steiman, Barry St. Charles	189
Stockwood, Robert C Sedalia	178
Strobach, Kurt F St. Louis	190
Stuppy, Mark S Springfield	082
Su, Philo S Jefferson City	058
Sullivan, Bradley H Kansas City	125
Taute, Hermann St. Louis	190
Tegeler, Kent E Liberty	050
Tendai, Mark M Springfield	082
Thomas, Jonathan L Cape Girardeau	042
Thompson, M. Bryant Chesterfield	190
Thomure, Michael F St. Louis	002
Thornton, Michael K Ste. Genevieve	174
Tobey, Albro C, Jr. St. Louis	190
Tobler, Randall W St. Louis	190
Trammell, Lee W Columbia	026
Treacy, Bryan J Bolivar	066
Triplett, Daniel A Liberty	050
Trumbower, William D Columbia	026
Turano, William L Raytown	125
Vajaranant, Manit Lexington	118
Van Dyke, Elmer H Sedalia	178
Villamar, Elizabeth N St. Louis	190
Vivian, Gary D St. Peters	189
Wagner, Daniel G Chesterfield	002
Walker, Gary K Springfield	082
Walker, J Leslie St. Louis	190
Wallace, Darryl L Kansas City	125
Walley, Lynn J Hannibal	150
Walsh, Barbara A St. Louis	190
Wasserman, Gary M St. Louis	190
Wasserman, Mark S St. Louis	190
Weinstein, David L St. Louis	190
Wheeler, Paul D Liberty	050
White, Eugene F Rolla	135
Whitten, J. Stephen Cape Girardeau	042
Wilbois, Ronald P St. Louis	190
Williams, Fred Columbia	026
Williams, John W, IV Springfield	082
Wolaniuk, Anna C St. Charles	190
Wright, Andy J Springfield	082
Yahnke, David G Farmington	138
Yang, John S Ste. Genevieve	174
Yazdi, Tom M St. Louis	190
Yeast, John D Kansas City	125
Yoon, Jin S Chillicothe	078
Youngblood, James P Kansas City	125

Occupational Medicine (OM)

Armbruster, A. A Stilwell, KS	002
Baker, John H St. Louis	190
Beeks, John W Kansas City	125
Belz, Norbert T Springfield	082
Bogner, Stuart M St. Louis	190
*Bynum, Carl G Jefferson City	058
*Cooper, Glen E Columbia	026
Kopp, Shelby K St. Louis	190
Meadows, C. Douglas St. Louis	190
Paff, David G Springfield	082
Patel, Ashokkumar B St. Louis	190
Stenberg, Michael D Kansas City	050
Vale, Janie R Columbia	026

Oncology (ON)

CaRolla, Robert L Springfield	082
Cipperly, Vaughan R Joplin	102
Coe, Tracy L Joplin	102
Cox, W. Welby Springfield	082
Cunningham, William F Springfield	082
Fleming, Allan R Kansas City	125
Hanson, Karl H Kansas City	125
Honeycutt, Pamela J Columbia	026
Hoos, Gary L Springfield	082
Janney, Stephen K St. Louis	190
Khojasteh, Ali Columbia	026
LaFrancis, Irving E Joplin	102
Matthews, Richard H Rolla	135
Morris, R. William St. Louis	190
Ota, David M Columbia	026
Perry, Michael C Columbia	026
Picus, Joel St. Louis	002
Schlossman, David M Columbia	026
Skelley, Mark J Joplin	102
Stephenson, William T Kansas City	125
*Stillie, G. Donald Kansas City	125
VanAmburg, Albert L, III Chesterfield	190
Yuen, Benjamin H Cape Girardeau	042

Ophthalmology (OPH)

Amin, Navin J St. Louis	190
Arnold, Paul N Springfield	082
Arribas, Neva P St. Louis	190
Avins, Laurence R St. Louis	190
Barnes, Charles H Kansas City	125
Bass, Walter R Raytown	125
Bauman, Alan E Kansas City	125
Becker, Bernard St. Louis	190
Becker, Rolfe A Kansas City	125
Becker, Stanley C St. Louis	190
Becker, William L St. Louis	190
Benedett, Robert E Springfield	082
Berdy, Gregg J St. Louis	190
Berg, Edward F Chesterfield	190
Blair, Jerry R Columbia	026
Bohigian, George M St. Louis	190
Bonham, Roger D Columbia	026
Boniuk, Isaac St. Louis	190
Bowen, Stephen F, Jr. St. Louis	190
Brady, Harry R St. Louis	190
Brigham, David W Ballwin	190
Bruce, Leo A Sikeston	202
Burgess, Dean St. Louis	190
Byars, Steven R Kansas City	125
Canaan, Samuel A, Jr. St. Louis	190
Carney, Susan M Kansas City	050
Case, William F Kansas City	125
Catanzaro, Frank J, Jr. St. Louis	190
Chipongian, Raul A St. Louis	190
Chishti, M. Ishaq St. Louis	190
Chu, Fred C Chesterfield	190
Chung, Sophia M St. Louis	190
Cibis, Gerhard W Kansas City	125
Clever, Victor G St. Charles	189
Cokingtin, Cliff Overland Park, KS	125

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Cowden, John W	Columbia	026
Cozean, Charles H	Cape Girardeau	042
Cundiff, H. Clay	Independence	125
Deligeorges, John	Kansas City	050
Del Priore, Lucian V	St. Louis	002
Durrie, Daniel S	Kansas City	125
Eggleston, Harry C	St. Louis	190
Eggleston, Thomas F	St. Louis	190
Ellis, Jean H	Blue Springs	125
Escoffery, Richard F	Florissant	190
Faulkner, C. Byron	Springfield	082
Fitz, John R	Farmington	138
Fivian, Gerald J	St. Louis	190
Ford, Thomas E	Niagara Falls, NY	190
Gabel, Michael G	St. Louis	190
Gans, Lawrence A	Florissant	190
Gehrs, Karen M	Kansas City	125
Gessler, James A	Springfield	082
Giangiacomo, Joseph	Columbia	026
Gigantelli, James W	Columbia	026
Goltschman, John P	Florissant	190
Gordon, James M	Florissant	190
Grand, M. Gilbert	St. Louis	190
Green, Morton R	Belleville, IL	190
Hagan, John C, III	N. Kansas City	050
Hart, William M, Jr.	St. Louis	190
Hartstein, Jack	Chesterfield	190
Harvey, Judith E	Springfield	082
Hembree, Kathryn A	Liberty	050
Holds, John B	St. Louis	190
Holekamp, Timothy	Columbia	026
Horton, Bill G	Springfield	082
Hunkeler, John D	Kansas City	125
Hyde, Lawrence L	Kansas City	125
Johnson, Cindi K	St. Joseph	030
Johnson, Lenworth N	Columbia	026
Jones, Robert W	West Plains	206
***Jordan, Earl L, Jr**	Joplin	102
Jung, J. Marshall	Cape Girardeau	042
Kamenetzky, Stephen A	St. Louis	190
Kaplan, Henry J	St. Louis	190
Kapp, Mary Beth	Cape Girardeau	042
Kass, Michael A	St. Louis	190
Kayes, Jack	St. Louis	190
Kenneally, Cynthia Z	St. Louis	190
Kies, Richard L	Cape Girardeau	042
Knopf, Harry L	St. Louis	190
Koenig, Marvin I	St. Louis	190
Kolker, Allan E	St. Louis	190
Korenfeld, Michael S	Washington	074
Kretchmar, Alan P	St. Louis	190
Krummenacher, Thomas K	St. Louis	190
Lederer, Charles M, Jr.	Kansas City	125
Lee, King Y	Shawnee Mission, KS	125
Leibsohn, Joel M	Independence	125
Lentz, Kathy J	Washington	074
Levenson, Ernest	Poplar Bluff	034
Lewis, Matthew T	Jefferson City	058
Lewis, Robert D	St. Louis	190
Linde, John W	Rolla	135
Lubniewski, Anthony J	St. Louis	190
Luetkemeyer, James G	Jefferson City	058
Lyon, David B	Prairie Village, KS	125
Matta, Camille S	Kansas City	125
Mattax, James B, Jr.	Springfield	082
McCabe, Eugene J	St. Charles	189
McGonigle, James P	Joplin	102
McKnight, Scott J	Liberty	050
Mehlhorn, Gary L	Springfield	082
Michaels, Robert H	Springfield	082
Milder, Barry D	St. Louis	190
Miller, James E	St. Louis	190
Morey, Kirk P	St. Louis	190
Morgan, Stephan S	St. Louis	190
Morrison, Tom V	Branson	208
Murphy, James A	St. Joseph	030
Neu, Kenneth W	Springfield	082
Neu, Leo T, III	Springfield	082
Newman, Matthew	St. Louis	190
O'Donnell, Francis E	St. Louis	190
Olk, R. Joseph	Chesterfield	002
Olson, E. Rule	Springfield	082
Ott, F. Thomas	St. Louis	190
Pepose, Jay S	St. Louis	002
Perlmutter, John C	St. Charles	189
Pernoud, Flavius G, III	St. Louis	190
Pernoud, Joan M	St. Louis	190
Peterson, Craig A	Springfield	082
Piebenga, Larry W	Kansas City	125
Place, Kenneth C	Kansas City	125
Plowman, Edward M	Hannibal	150
Pojanasomboon, Pichat	Rolla	135
Prater, Thomas G	Springfield	082
Price, Patrick K	Shawnee Mission, KS	125
Purcell, John J, Jr.	St. Louis	190
Rahman, Moududur	Chesterfield	190
Reddy, Nalini A	West Plains	206
Rednam, Krishnarao V	Kirkwood	190
Revels, Harry R, III	Leawood, KS	125
Ridgeway, William G	St. Louis	190
Rieger, Frank G	Columbia	026
Ringer, C. Nelson	Cape Girardeau	042
Robinson, James C	Columbia	026
Rogers, Casey	Mexico	014
Rosenthal, William N	Kansas City	125
Sabates, Felix N, Sr.	Prairie Village, KS	125
Sabates, Nelson R	Prairie Village, KS	125
Sabates, Roland	Kansas City	125
Salmon, M. L.	Palm Harbor, FL	190
Samudrala, Ramulu	St. Louis	190
Schanzlin, David J	St. Louis	190
Schoch, Lawrence H	Florissant	190
Schoengarth, Lowell D	Columbia	026
Schrenk, Loren C	St. Louis	002
Scott, Wendell J	Springfield	082
Shah, Ramesh R	Joplin	102
Shelton, R. Wayne	Springfield	082
Short, Howard N	Washington	074
Siegfried, Carla J	Ballwin	190
Sigmund, Charles A	Bridgeton	190
Silver, Bernd	St. Louis	190
Silverstein, Steven M	Kansas City	125
Slocum, Stephen G	St. Louis	190
Smith, Porter	Poplar Bluff	070
Spalding, David L	Springfield	082
Spalding, Wilber B, Jr.	Kansas City	125
Spurrier, Mark H	St. Louis	190
Stafford, Walter R	St. Louis	190
Stauffer, Larry K	Jefferson City	058
Stewart, L. Paul	St. Louis	190
Stiles, Michael C	Kansas City	125
Stout, Carl N	Independence	125
Tekwani, Hiralal T	St. Louis	190
Tess, Allen F	Florissant	190
Thomas, Matthew A	St. Louis	190
Tobin, Robert F	St. Joseph	030
Traxel, William L	Poplar Bluff	034
Tyler, Thomas D	Richmond	118
Unwin, Donald R	St. Louis	002
Walline, T. Andrew	Kansas City	125
Wankum, Robert P	Jefferson City	058
Watson, Richard A	St. Joseph	030
Wax, Martin B	St. Louis	190
Weir, Robert K	Kansas City	125
Westrich, David J	Cape Girardeau	042
Wexler, Stephen A	St. Louis	190
Whitacre, Marc M	Prairie Village, KS	125
White, William L	Kansas City	125

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Wiles, Stephen B	Kansas City	**125**
Wills, Theodore E	Columbia	**026**
Wolf, Mitchel L	St. Louis	**190**
Wurster, Jerry B	Kansas City	**125**
Yang, H. Kell	Columbia	**026**
Young, Thomas J	St. Joseph	**030**
Ziemianski, Matthew C	Kansas City	**125**

Orthopedic Surgery (ORS)

Abernathie, Dennis L	Columbia	**026**
Adams, Allen G	St. Louis	**190**
Adams, Mark A	Columbia	**026**
Adler, Federico	Kansas City	**125**
Alander, Dirk H	Kansas City	**125**
Allen, William Corwin	Columbia	**026**
Anderson, David J	St. Louis	**190**
Anglen, Jeffrey O	Columbia	**026**
Aubuchon, Craig E	St. Louis	**190**
Badwey, Timothy M	Kansas City	**125**
Baldwin, Richard , Jr.	St. Louis	**190**
Ball, David A	Joplin	**102**
Barnthouse, Cris D	Kansas City	**125**
Bassman, Donald R	St. Louis	**190**
Beall, McPherson S, Jr.	Kansas City	**125**
Beckett, Wm. Wilson	Columbia	**026**
Belew, Mark	Florissant	**190**
Benson, William F	Kansas City	**125**
Bernhardt, Mark	Kansas City	**125**
Bieniek, Christopher M	Hannibal	**150**
Black, David L	Joplin	**102**
Blair, Vilray P, III	St. Louis	**190**
Bliss, Greg A	Independence	**125**
Bohn, William W	Kansas City	**125**
Bonar, Susan K	Kansas City	**125**
Boylan, Peter C	Kansas City	**125**
Brancato, Donald H	St. Louis	**190**
Brennan, Richard J	St. Joseph	**030**
Britt, Cornelius L	Crystal City	**106**
Brown, David W	Springfield	**082**
Browne, Jon E	Kansas City	**125**
Bruce, Robert P	Kansas City	**125**
Buchert, Peter K	Columbia	**026**
Burdge, Robert E	St. Louis	**190**
Burke, James S, Jr.	St. Louis	**190**
Burleigh, Bruce W	Joplin	**102**
Burns, Michael F	St. Louis	**190**
Burton, Curtis D	Hannibal	**150**
***Cameron, Roger W**	Jefferson City	**058**
Chalk, David E	Washington	**074**
Cho, Kyu S	St. Louis	**190**
Clarke, Michael S	Springfield	**082**
Clothiaux, Pierre L	Springfield	**082**
Collins, John W, Jr.	Independence	**125**
Cordell, Larry D	Kansas City	**125**
Couchman, Ryan W	St. Louis	**190**
Cunningham,R.Raymond	Columbia	**026**
Curnow, Richard B	Liberty	**050**
Darnell, Dale E	Kansas City	**125**
Davis, Leonard L	Columbia	**014**
DiFilippo, Emil A	St. Charles	**189**
Dillard, Erin M	Springfield	**082**
Doerr, Dale E	St. Louis	**190**
Downs, Daniel M	Kansas City	**125**
Dubin, Sol H	Independence	**125**
Dugan, Gerald F	Kansas City	**125**
Duncan, Douglas M	Springfield	**082**
Dusek, Dennis A	St. Louis	**190**
Eckenrode, James F	Columbia	**026**
Edwards, Ryan K	Sedalia	**178**
***Ellefsen, Brian K**	Carthage	**102**
Eller, Gordon W	Cape Girardeau	**042**
Ellfeldt, Howard J	Kansas City	**125**
Ellsasser, James C	Rocheport	**026**
Emanuel, James P	St. Louis	**190**
Esch, John G	Joplin	**102**
Evans, Lawrence G, Jr.	St. Louis	**190**
***Farley, Gary W**	St. Louis	**190**
Fox, Thomas J	St. Louis	**190**
Frank, Gael R	N. Kansas City	**125**
Frevert, Larry F	Kansas City	**125**
Frewin, Paul R	Springfield	**082**
Frumson, Guy H	Florissant	**190**
Gaines, Robert W	Columbia	**026**
Gainor, Barry J	Columbia	**026**
Gelberman, Richard H	St. Louis	**190**
Gilden, Jerome J	St. Louis	**190**
Glaser, Larry F	Cleveland	**125**
Gondring, William H	St. Joseph	**030**
***Graven, Timothy G**	Festus	**106**
Grillot, Michael B	Springfield	**082**
Gunter, Kevin G	Sedalia	**178**
Gurba, Danny M	Kansas City	**125**
Haas, Robert W	Liberty	**050**
Hammond, D. Wade	St. Louis	**190**
Harmon, Ben C	Springfield	**082**
Harris, Hugh G	Springfield	**082**
Harris, Lanny W	Kansas City	**125**
Haupt, Herbert A	St. Louis	**190**
Havey, John	Columbia	**026**
Hernandez, Salvador R	St. Louis	**190**
Highland, Thomas R	Columbia	**026**
Hoffmann, Ronald E	St. Louis	**190**
Holand, Roy W	Springfield	**082**
Hollocher, Richard J	St. Louis	**190**
Holt, Benjamin T	Columbia	**026**
Hummel, Gregory L	Independence	**125**
Humphreys, William	St. Joseph	**030**
***Hunter, Harlen C**	Chesterfield	**190**
Jarka, Dale E	Kansas City	**125**
Jeffries, Joel T	Columbia	**026**
Jelley, V. Carl	Blue Springs	**125**
Johnson, Glen E	St. Louis	**190**
Johnston, Richard	St. Louis	**190**
Jolly, Ben L	Mexico	**014**
Jones, Bruce N	Chesterfield	**190**
Jones, Lowry , Jr.	Kansas City	**125**
Jones, Robert P	Blue Springs	**125**
Joyce, Steven T	Kansas City	**125**
Kapp, William K, III	Cape Girardeau	**042**
Kefalas, John C	Washington	**074**
Kenney, John D	St. Louis	**190**
Keohane, Mark	St. Charles	**189**
Kiburz, Douglas W	Sedalia	**178**
Koch, F. Daniel	Kansas City	**125**
Kramer, Robert S	St. Louis	**190**
Krautmann, John J	Jefferson City	**058**
Kriegshauser, Lawrence A	St. Louis	**190**
Lange, David R	Bridgeton	**190**
Lee, Thomas K	St. Louis	**190**
Lehman, Richard C	St. Louis	**190**
Lents, Rickey L	Cape Girardeau	**042**
Leslie, James T	Jefferson City	**058**
Linsenmeyer, Charles M	St. Charles	**189**
Littlejohn, Robert T	N. Kansas City	**050**
Lord, Richard E	St. Louis	**190**
Luechtefeld, Frank	Florissant	**190**
Luther, George A	St. Louis	**190**
Mahnken, Robert F	Springfield	**082**
Mannis, Charles I	St. Louis	**190**
Manske, Paul R	St. Louis	**190**
Marshall, Michael P	Kansas City	**002**
Marti, Larry B	Rolla	**135**
Martin, Daniel J, Jr.	St. Louis	**190**
Martin, Jeffrey W	St. Louis	**190**
Matava, Matthew	St. Louis	**190**
Matthews, Thomas D	Washington	**074**
Maylack, Fallon H	Florissant	**190**

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McAllister, John W, II	St. Peters	189
McClain, Thomas D	Springfield	082
McMillin, John N	Springfield	082
McMullin, Forbes A	St. Louis	190
McMurray, Scott W	Springfield	082
McQueary, Frederick G	Springfield	082
Mell, Roger L	Chesterfield	190
Merenda, Frank J	St. Louis	190
Merenda, James T	St. Louis	190
Merkel, Kurt D	St. Louis	190
Miller, Harry G	Clinton	086
Mirbaha, Mitchell M	St. Louis	190
Morris, Alan H	St. Louis	190
Morse, John P	Kennett	070
Nachtigal, Michael P	Springfield	082
Neighbor, Ernest H	Kansas City	125
Nogalski, Michael P	St. Louis	190
Olive, Paul M	Springfield	082
***Page, Lawrence V**	Joplin	102
Parker, Jeffrey W	Columbia	026
Parkins, George K	Kansas City	125
Parsons, Clyde W, III	Springfield	082
Pawsat, John E	Kansas City	125
Petkovich, Frank O	St. Louis	190
Phillips, John J	Florissant	190
Phillips, Thomas P	Kansas City	125
Piontek, Jerome G	Chesterfield	190
Piper, Terrence L	St. Peters	189
Pomphrey, Martin M, Jr.	Chesterfield	190
Putnam, John L	Springfield	082
Reardon, James P	N. Kansas City	050
Reeves, R. Bradley	Joplin	102
Rhoades, Charles E	Kansas City	125
Rich, Margaret M	St. Louis	190
Rispler, David T	Jefferson City	058
Ritter, R. August , III	Cape Girardeau	042
Ritter, Ray A, Jr	Cape Girardeau	042
Rogers, David B	Springfield	082
Rose, Barry A	Overland Park, KS	125
Rosenthal, Howard G	Kansas City	125
Roush, Randall D	Florissant	190
Russell, Garth S	Columbia	026
Ryan, Thomas J	Jefferson City	058
Samson, Barry L	St. Louis	190
Samuelson, Thomas S	Kansas City	125
Sanchez, Jon J	Springfield	082
Sandow, Theodore L	Kansas City	125
Satterlee, C. Craig	Kansas City	125
Schaberg, James E	St. Charles	189
Schlafly, Bruce S	St. Louis	190
Schlafly, Edward F, Jr.	Chesterfield	190
Schmidt, Thomas L	Kansas City	125
Schoedinger, George R, III	St. Louis	190
Schoenecker, Perry L	St. Louis	190
Schroer, William C	Bridgeton	002
Schwarze, Daniel J	St. Louis	190
Scott, Andrew	Kansas City	125
Seagrave, Richard A	Springfield	082
Sedgwick, William G	St. Louis	190
Sertl, George O	St. Louis	190
Shaeffer, James T	Springfield	082
Shaffer, William O	St. Louis	190
Sheridan, John J	St. Louis	190
Shitut, Ravindra V	St. Louis	190
Shively, Robert A	St. Louis	190
Sicat, Alfonso V	Warrensburg	110
Skimming, W. Lee	St. Louis	190
Smith, Bruce D	St. Joseph	030
***Smith, C. Daniel**	St. Joseph	030
Smith, Kenneth R	Bolivar	206
Smith, Patrick A	Columbia	026
Stokes, Douglas L	St. Joseph	030
Strecker, William B	St. Louis	190
Strickland, James C	St. Louis	190
***Stringer, Robert F**	Joplin	102
Strong, Alexandra J	Kansas City	125
Stronsky, David	St. Louis	190
Sudekum, Joseph M	St. Louis	190
Sundstrom, Frank D	Springfield	082
Susi, Jesse G	St. Louis	190
Sutherland, Charles J	St. Louis	190
Swaim, Truett	Blue Springs	125
Swango, John S	Springfield	082
Takacs, Robert J	Kansas City	125
Tessier, John E	St. Louis	190
Thomas, Leslie D	N. Kansas City	050
Thorpe, William P	Cape Girardeau	042
Tillema, David A	Kansas City	125
Trecha, Randal R	Columbia	026
True, John H	Poplar Bluff	034
Trueblood, Michael C	Cape Girardeau	042
Tucker, Robert E	St. Louis	190
Tupper, Joel	Joplin	102
Turnbaugh, Thomas R	Jefferson City	058
Turner, Michael L	Poplar Bluff	034
Van Ryn, Jacques S	Bridgeton	190
Veitch, John M	Joplin	102
Vierling, Stephen E	St. Louis	190
Vilmer, Charles E	N. Kansas City	050
Vilmer, Stephen E	N. Kansas City	050
Wagner, John R	St. Louis	190
Wakeman, Newt , Jr	Springfield	082
Wayne, Sherwyn J	St. Louis	190
Weed, Daniel D	Kansas City	125
Weise, Marc W	St. Louis	190
Weltmer, John B, Jr.	St. Louis	190
West, Harold D	Independence	125
Whitaker, James H	Kansas City	125
White, Newton B	St. Louis	190
Whiteside, Leo A	St. Louis	190
Williams, Joseph	St. Louis	190
Wittgen, Edward M	St. Louis	190
Wolf, Marion L	Springfield	082
Wright, Rick W	St. Louis	190
Wynkoop, Walker A	Cape Girardeau	042
Yost, John G, JR	Kansas City	125
Zehnder, Kenneth W	St. Louis	190
***Zipper, Ronald**	N. Kansas City	050

Other (OS)

Rotskoff, Kenneth S	St. Louis	190

Otolaryngology (OTO)

Ailor, Edgar I	Columbia	026
Allphin, Allan L	Springfield	082
Barnhill, Floyd R	Springfield	082
Bart, Gerald N	St. Louis	190
Benecke, James E, Jr.	St. Louis	190
Berkowitz, Wallace P	St. Louis	190
Bonacorsi, John	Bridgeton	190
***Bosley, Carl E**	Poplar Bluff	034
Boyd, James H	St. Louis	190
Branham, Gregory H	St. Louis	190
Brown, Rebecca L	Springfield	082
Burroughs, Nathan D	N. Kansas City	050
Campbell, Gregory S	Columbia	026
Christiansen, Sidney G	St. Joseph	030
***Coffman, Avon C**	Kansas City	125
Cook, Paul R	Columbia	026
Coonce, Don C	Cape Girardeau	042
Cotton, Thomas R	Kansas City	125
Craig, Robert D	St. Louis	002
Davis, Sheldon	Florissant	190
Davis, William E	Columbia	026
Denninghoff, James S	Columbia	026
Devine, Mark W	N. Kansas City	050
Dlabal, Luke J, Jr.	Independence	125

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Donovan, Thomas J	**190**	St. Louis
Druck, Norman S	**190**	Chesterfield
Dunfield, Jay A	**125**	Kansas City
Ehrlich, Carl F	**190**	St. Louis
Eisenbeis, John F	**190**	St. Louis
Ellis, John C	**125**	Independence
Estrem, Scott A	**026**	Columbia
Freeman, Jerry C	**125**	Kansas City
Friedman, William H	**190**	St. Louis
Goebel, Joel A	**190**	St. Louis
Guastello, Joseph R	**125**	Kansas City
Guastello, Mario J	**125**	Kansas City
Hahn, Frederick W	**125**	Independence
Hantz, Oscar	**190**	Florissant
Hartman, James M	**190**	St. Louis
Herzog, Jacques A	**190**	Chesterfield
Hill, David K	**125**	N. Kansas City
Hughes, Michael F	**125**	Kansas City
Ingram, Donald R	**190**	Festus
Ippensen, John H	**082**	Springfield
Jung, Christopher H	**042**	Cape Girardeau
Katsantonis, George	**190**	St. Louis
Kendall, Forrest H	**125**	Kansas City
King, Dana M, III	**030**	St. Joseph
Kirsch, Jeffrey P	**190**	St. Louis
Kletzker, George R	**190**	St. Louis
Knudson, Dennis R	**026**	Columbia
Krebs, Festus J, III	**125**	Kansas City
Kroeger, George B, Jr.	**190**	St. Louis
Lampros, William P	**190**	St. Louis
Levine, Laurence A	**190**	St. Charles
Lima, Jose A	**190**	St. Louis
Loynd, Robert C	**190**	St. Louis
Luetje, Charles M	**125**	Kansas City
Mangum, William B	**125**	Independence
Marchiando, Albert W	**074**	Washington
Martin, Richard A	**042**	Cape Girardeau
Marty, David R	**058**	Jefferson City
Maslan, Mark J	**125**	Overland Park, KS
McDonald, Robert J	**058**	Jefferson City
McGonigle, Michael M	**102**	Joplin
McKenzie, Randolph A	**125**	Kansas City
McKinney, John W	**190**	St. Louis
Mertz, Janet S	**125**	Kansas City
Moritz, Gerald	**190**	Bridgeton
Neely, J. Gail	**190**	St. Louis
Pavlovich, Andrew S	**125**	Independence
Phipatanakul, Supote	**190**	Kirkwood
Piccirillo, Jay F	**190**	St. Louis
Reichert, Timothy J	**190**	St. Louis
Renner, Gregory J	**026**	Columbia
Ridenour, Brock D	**190**	St. Louis
Robinett, Wade V	**125**	Kansas City
Roh, Lynn H	**125**	Kansas City
Schrick, Richard E	**190**	St. Louis
Schroeder, Walter A, Jr.	**042**	Cape Girardeau
Seiden, Gerald D	**125**	Kansas City
Sessions, Donald G	**190**	St. Louis
Shagets, Frank W	**102**	Joplin
Sherman, David M	**082**	Springfield
Shuff, Paul D	**190**	St. Louis
Singleton, Marvin A	**102**	Joplin
Smith, Courtland P, Jr.	**070**	Kennett
Smith, Peter G	**190**	St. Louis
Snow, Jon F	**082**	Springfield
Spake, R. Vanneman	**125**	Kansas City
Stith, John A	**190**	St. Louis
Stroble, Mark	**190**	St. Louis
Templer, Jerry W	**026**	Columbia
Thawley, Stanley E	**190**	St. Louis
Thedinger, Bradley S	**125**	Kansas City
Thomas, Robert M	**026**	Columbia
Thornton, F. Parker , III	**125**	Overland Park, KS
Viers, Wayne A	**190**	St. Louis
Vighi, James R	**189**	St. Charles
Walls, Kelvin	**125**	Independence
Waxman, Joel E	**082**	Springfield
Wible, Jerry C	**082**	Springfield
Wild, Alan P. K.	**190**	Chesterfield
Willman, Martin L	**189**	St. Charles
Wolfe, James B	**082**	Springfield
Yates, Karen	**042**	Cape Girardeau
Zitsch, Robert P, III	**026**	Columbia

Pathology (PTH)

Arthur, Gerald L	**026**	Columbia
Bari, Wagih A	**190**	St. Louis
Benson, Russell L	**125**	Kansas City
Blair, Olga M	**190**	St. Louis
Bollozos, George D	**190**	Chesterfield
Bourgeois, Curtis H	**026**	Columbia
Brangle, Robert W	**190**	St. Louis
Breckenridge, Robert L	**050**	Kansas City
Bucher, William C	**026**	Columbia
Burch, Timothy K	**125**	Overland Park, KS
Callaway, Lawrence A	**125**	Kansas City
Carlson, John V	**014**	Mexico
Case, Mary E	**190**	St. Louis
Caughron, Michael R	**125**	Kansas City
Cento, Donald P	**202**	Sikeston
Charles, Elaine Z	**190**	St. Louis
Costin, Jimmy L	**034**	Poplar Bluff
Craver, Jeffrey L	**190**	Bridgeton
Curry, Michael D	**026**	Columbia
Darkow, Grant V	**026**	Columbia
DeFeo, Theodore C	**125**	Kansas City
Dehner, Louis P	**190**	St. Louis
Dorzab, William E	**125**	Overland Park, KS
Dumadag, Virgilio P	**190**	St. Louis
Durr, Jon W	**190**	Florissant
Esther, John R	**102**	Joplin
Evans, Maria L	**026**	Columbia
Ferris, Charles W, Jr.	**190**	St. Louis
Fritzlen, Thomas J	**125**	Overland Park, KS
Galblum, Larry I	**125**	Kansas City
Gauthier, Charles P	**125**	Kansas City
Gerdes, John A	**082**	Springfield
Givler, Robert L	**125**	Kansas City
Hall, Stanley G	**150**	Hannibal
Hamel, Peter C	**150**	Hannibal
Henry, Lawrence D	**058**	Columbia
Henry, Mary M	**125**	Kansas City
Hopson, David K	**190**	St. Charles
Horn, Paul C	**042**	Cape Girardeau
Hurly, Michael P	**102**	Joplin
Ingram, Ellis A	**026**	Columbia
Johnson, Gareth R	**125**	Independence
Johnson, Gordon L	**106**	Festus
Johnson, Steven M	**190**	St. Louis
Jones, Randall W	**125**	Independence
Kang, Juan	**190**	St. Louis
Keitges, Pierre W	**125**	Overland Park, KS
King, Gregory S	**190**	St. Louis
Kissane, John M	**190**	St. Louis
Kleopfer, Lynn L	**026**	Columbia
Kraus, Frederick T	**190**	St. Louis
LaBach, James P	**125**	Overland Park, KS
Landgraf, James R	**125**	Independence
Lombardo, Joseph A	**190**	St. Louis
Marshall, Hal E	**125**	Overland Park, KS
Martin, Scott A	**190**	Chesterfield
McDonald, Margaret E	**102**	Joplin
McIntire, Timothy L	**058**	Jefferson City
McMeekin, Sheila P	**125**	Shawnee Mission, KS
Millet, Ruth E	**125**	Kansas City
Morrison, R. Gideon	**178**	West Plains
Ost, Mark D	**125**	Kansas City
Paez, Mauro A	**190**	St. Louis

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Patrick, Roman L	St. Louis	190
Perez, Blanca M	St. Louis	190
Peterson, Ila M	Overland Park, KS	125
Pintado, Susan O	Joplin	102
Pittman, David L	Columbia	026
Pittman, Gerald R	St. Louis	190
Poger, Marshall E	St. Louis	190
Prey, Marianne U	St. Louis	190
Racela, Luz S	Leawood, KS	125
Ramos, Richardo R	St. Louis	190
Rao, Sumati	St. Louis	190
Rawson, Perry G	Washington	074
Rollo, John L	St. Louis	190
Salvador, Antonio	St. Louis	190
Seitz, Elson F	Independence	125
Shah, Sheila	St. Joseph	030
Sheley, James M	Springfield	082
Short, Charles D	St. Louis	190
Silliman, York E	St. Joseph	030
Smid, David M	Springfield	082
Stahr, William D	Cape Girardeau	042
Sueper, Robert H	St. Louis	190
Summerfield, Anita	Springfield	206
Swank, Darrell	Joplin	102
Turgeon, Ronald P	St. Louis	190
Vergara, Gerardo G	Kansas City	125
Villanueva, Angela A	Overland Park, KS	125
Vo, Thuy-Lieu T	St. Louis	190
Wachter, Ronald M	Springfield	082
Zacharias, Sara	Columbia	026

Pediatrics (PD)

Aceto, Thomas, Jr.	St. Louis	190
Adams, Susan E	St. Louis	190
Allen, Jerry H	Washington	074
Amjad, Mohammad T	St. Louis	190
Andrews, Elizabeth J	Springfield	082
Baker, Marion H	Jefferson City	058
Barker, Edward T	St. Louis	190
Barter, Bruce	Leawood, KS	125
Beesley, Kari	Kansas City	002
Belen, Marietta	Festus	106
Benoist, Walter F	Chesterfield	190
Berman, Paul M	St. Louis	190
Birmingham, Jean E	St. Louis	190
Black, Donald R	Springfield	082
Blim, R. Don	Kansas City	125
Bloomberg, Gordon R	Chesterfield	190
Bordy, Marvin D	Kansas City	125
Bost, Roger K	Poplar Bluff	034
Bouhasin, John D	St. Louis	190
Bowers, James E	Kirkwood	190
Braddock, Stephen	Columbia	026
Brady, Teresa M	Raytown	125
Brehm, Martha A	Joplin	102
Britton, Loretta M	Kansas City	125
Bunge, Nancy J	Mexico	014
Burgdorf, Max H	Bridgeton	190
Bussmann, Yvonne L	Springfield	082
Cantor, Harvey E	St. Louis	190
Carnahan, Charles E	Columbia	026
Casey, Eliot C	St. Louis	190
Charette, Richard P	Kansas City	125
Chauhan, Nazar C	Poplar Bluff	034
Chun, Chung S	Kansas City	125
Clever, Henry W	St. Charles	189
Cockerell, Charles F	Blue Springs	125
Cokingtin, Diana L	Kansas City	125
Cokingtin, Leovigildo C	Independence	125
Conley, Brian S	Jefferson City	058
Cook, Katherine S	Rolla	135
Dattel, F. Scott	Raytown	002
DeCastro, Fernando J	Pilot Knob	138
Dempsey, Maureen E	Columbia	026
DeSilva, Ananda	Hazelwood	190
Diehl, Elizabeth W	St. Louis	190
Dinkins, James A	Cape Girardeau	042
Duling, Gerald J	St. Charles	189
Espaillat, Jose A	Sikeston	202
Ewing, Lesley L	Kansas City	125
Farberman, Elliott	Florissant	190
Fernandez, Fernando	St. Joseph	030
Floyd, Marla J	Springfield	082
Flug, Eric J	St. Louis	190
Forgue, Donald R	Kansas City	125
Friedman, Ira J	Washington	074
Fusselman, Jon M	Springfield	082
Gassman, Ann A	Kansas City	125
Gauer, Robert J	Kansas City	050
Gellman, Elliot F	St. Louis	190
Glines, Michael H	Arnold	190
Goldberg, Joseph P	Overland Park, KS	125
Goldstein, David E	Columbia	026
Goler, Michael R	Springfield	082
Goodman, Gary M	Chesterfield	190
Greene, Walter B	Columbia	026
Griesemer, Bernard A	Springfield	082
Groshong, Ted D	Columbia	026
Grunt, Jerome A	Kansas City	125
Guyer, Emily	Columbia	026
Hall, Robert T	Kansas City	125
Hanks, Michael S	Springfield	082
Hansen, Thomas L	Independence	125
Harris, David J	Kansas City	125
Harrison, Thomas J, Jr.	St. Charles	189
Harwell, J. Larry	St. Louis	190
Hellweg, Raymond W	Florissant	190
***Hennan-Hain, Pearl E**	Joplin	102
***Hoffman, James E**	Cape Girardeau	042
Holmes, Nancy E	St. Louis	190
Horan, John J, Jr.	St. Louis	190
Howard, Campbell P	Kansas City	125
Ip, Aidan W	St. Louis	190
James, Elizabeth J	Columbia	026
Jones, Robert R	Nevada	214
Kahn, Joseph A	St. Charles	189
Kanarek, Joseph	Kansas City	125
Keefe, David M	St. Charles	189
Kemp, Michele E	Chesterfield	190
Khan, Abdul G	Arnold	190
Khurana, Satish K	Lenexa, KS	125
Knapp, Jane F	Kansas City	125
Knock, Henry L	St. Louis	190
Kosse, Karl E	St. Joseph	030
Krahn, Eve M	Kansas City	050
Kreusser, Katherine L	St. Louis	190
Krishna, Padma	Kansas City	125
Kronemer, Norton S	St. Louis	190
Lieb, Francis X	St. Louis	190
Limpiphiphatn, Ester P	Perryville	174
Mann, James K	Hannibal	150
McElroy, George L, III	Jefferson City	058
McIntosh, Michele C	Independence	125
McKinney, Daniel C	Springfield	082
McNeal, Douglas M	Springfield	082
Mestres, Hugh M	St. Louis	190
Meyer, John W	Springfield	082
Miller, Suzanne L	Grover	190
Mitra, Nirmal K	Kansas City	125
Monteleone, Patricia L	St. Louis	190
Morgan, Mary	St. Louis	002
Motier, Thomas H	St. Louis	190
Muraywid, Ahmad H	Mexico	014
Murphy, Timothy P	St. Joseph	030
Nash, Alison C	St. Louis	190
Nash, Homer E, Jr.	St. Louis	190
Newman, William R	Joplin	102
Nicholis, G. Ronald	Kansas City	125

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Nile, David A	St. Louis	190
Nitta, Diane M	Springfield	082
Olson, Gary S	Cape Girardeau	042
O'Neil, Jerome H, Jr.	St. Louis	190
Oppermann, Karen J	Independence	125
Otis, Stephanie A	St. Louis	002
Overend, Don S	Springfield	082
Palcheff, Chris L	Springfield	082
Peterson, Frederick D	St. Louis	190
Phillips, Abraham M	St. Louis	190
Pitiyanuvath, Tasanaporn	Kansas City	125
Plax, Steven I	St. Louis	190
Powell, Alan E	Independence	125
Reed, Timothy F	Sedalia	178
Rejent, Anthony J	St. Louis	190
Reyes, Lirio M	Springfield	082
Rice, Kathleen G	Springfield	082
Rising, Dean R	Springfield	082
Roberts, Charles C	Kansas City	125
Roberts, Phyllis G	St. Joseph	030
Ross, William J	Bridgeton	190
Sakmar, Douglas A	St. Louis	190
Sammon, T. James	Springfield	082
Sato, George	Chesterfield	190
Sato, Richard W	Chesterfield	190
Schlansky, Howard J	St. Charles	189
Schmidt, Martin P	St. Louis	190
Sharma, Vidya	Kansas City	125
Sheehan, Michael B	Kansas City	125
Sherman, W. Gary	Chesterfield	190
Simmons, Connie D	Cape Girardeau	042
Smith, Arnold L	Columbia	026
Solanki, Nareshkumar J	Wentzville	190
Sponenberg, Don D	Springfield	082
Stiaszny, Louis K	Kansas City	125
Sultan, Tipu	Florissant	190
Suseela, Dasari	Kansas City	125
Tenorio, Genoveva	Albany	158
Thompson, F Gregg	St. Joseph	030
Tillman, Mary A	St. Louis	190
Tolan, Robert W, Jr.	St. Louis	190
Trimmer, Jeanne M	St. Louis	190
Troug, William E	Kansas City	125
Tschudin, Garland	St. Louis	190
Tsifutis, Argyrios A	St. Louis	190
Tungsiripat, Soros	Kennett	070
Umar, Ibrahim S	St. Peters	189
Vietti, Teresa J	St. Louis	002
Walentik, Corinne	St. Louis	190
Walker, Orville C	Independence	125
***Wasserman, Gary S**	Kansas City	125
Waxelman, Roger J	Ballwin	190
Weldon, Virginia V	St. Louis	190
Westerfeld, Roy A	St. Charles	189
Wicklund, Brian M	Kansas City	125
***Wilson, James W**	Springfield	082
Wimmer, Warren J	Florissant	190
Wool, Gerald	St. Louis	190
Zahn, Robert L	Springfield	082

Pediatric Allergy (PDA)

Cannon, Richard E	St. Charles	189
Corry, James M	St. Louis	190
Siegel, Charles	Gladstone	050

Pediatric Cardiology (PDC)

Canent, Ramon V	Kansas City	125
Gowdamarajan, Rengasamy	Kansas City	125
Hubbell, Marius M, Jr.	Kansas City	125

Pediatric Radiology (PDR)

Ritter, John L	Springfield	082

Pediatric Surgery (PDS)

Ashcraft, Keith W	Overland Park, KS	125
Bell, Martin J	St. Louis	190
Cradock, Thomas V	St. Louis	190
Helikson, Mary A	Columbia	026
Manning, Peter B	Kansas City	125
Murphy, John P	Overland Park, KS	125
Sharp, Ronald J	Overland Park, KS	125
Ternberg, Jessie L	St. Louis	190

Physical Medicine & Rehabilitation (PM)

Al-Shathir, Saad	Joplin	102
Clark, Jennifer L	Columbia	026
Conway, Robert R	Columbia	026
Corsolini, Thomas B	Springfield	082
Del Rosario, John E	St. Louis	190
Gnatz, Steven	Columbia	026
Hoffarth, Sharon C	St. Louis	190
Karges, Melvin D	Kansas City	125
Kelly, Charles R	Kansas City	125
Knakal, Roger C	Kansas City	002
Lieb, Thomas F	St. Louis	190
Lytle, Edwin L	St. Louis	190
Mauldin, Charles C	Springfield	082
Middleton, Mary Jo	St. Joseph	030
Mohsen, Aly M	Springfield	082
Pryor, Harold J	Kansas City	125
Randolph, Bernard C, Jr.	Bridgeton	002
***Rupright, S. Jon**	Columbia	058
Wheeler, Eden	Independence	125
Wice, Martin B	St. Louis	190
***Woods, Brenda L**	Jefferson City	058
Zarr, James S	Kansas City	125

Plastic Surgery (PS)

Barnthouse, Joseph R	Kansas City	125
Bennett, Danny L	Kansas City	125
Cabbabe, Edmond B	St. Louis	190
Caplin, David A	St. Louis	190
Coin, Richard E	St. Louis	190
Copeland, Jeffrey G	St. Charles	189
Corwin, Kenneth D	St. Louis	190
Crandall, Richard E	Chesterfield	190
Crow, Martin L	Kansas City	125
Danielsson, Ernst P	Springfield	082
Deisher, David M	Cape Girardeau	042
DePriest, Michael D	St. Joseph	030
Domann, Darrel D	Springfield	082
Eades, Joseph W	Chesterfield	190
Ettelson, Charles D	Chesterfield	190
Feliciano, Wilfrido C	Maryland Hghts	190
Fortin, Don G	Kansas City	050
Francel, Thomas J	St. Louis	002
Geraghty, Thomas E	Kansas City	125
German, David S	St. Louis	190
Geter, Rodney K	Springfield	082
Goldstein, Marcy A	St. Louis	002
Gutek, E. Philip	Kansas City	125
Halford, Richard M	St. Louis	190
Hart, William G, Jr.	St. Louis	190
Heimburger, Richard A	Osage Beach	120
Higgs, Philip E	St. Louis	190
Huffaker, William H	Chesterfield	190
Johnson, Charles J	St. Louis	190
Jones, Timothy R	St. Louis	190
Kaplan, Michael F	Columbia	026
Kester, Carla G	Springfield	082
Khouri, Roger K	Key Biscayne, FL	190
Kofkoff, Richard L	Bridgeton	190
Koo, Michele D	St. Louis	190
Kraemer, Bruce A	St. Louis	190

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*Doctor of Osteopathy

Lakusiewicz, Ronald J Poplar Bluff	**034**
Lamb, Jerome P Blue Springs	**125**
Lomax, John E Branson	**208**
Lund, Herluf G, Jr. Chesterfield	**190**
MacKinnon, Susan E St. Louis	**190**
Marsh, Jeffrey L St. Louis	**190**
McClung, Mark W Kansas City	**125**
McGuire, Patricia A St. Louis	**190**
Meystrik, Rosellen S Springfield	**082**
Mischnick, Carol R Chesterfield	**190**
Mossie, Raymond D Kansas City	**050**
O'Connell, Timothy St. Louis	**190**
Onken, Henry D St. Louis	**190**
Payne, Meredith C Chesterfield	**190**
Price, Carl I Springfield	**082**
Puckett, Charles L Columbia	**026**
Reddy, R. Ramachandra Cape Girardeau	**042**
Reynolds, William R Springfield	**082**
Ribaudo, J. Michael St. Louis	**190**
Rinehart, Gregory C St. Louis	**190**
Rottler, Paul D St. Louis	**190**
Ruehl, Albert F St. Louis	**190**
Scheu, James H St. Peters	**190**
Seaberg, John J, III Columbia	**026**
Sherrod, Duane W Joplin	**102**
Stevens, Sheridan Independence	**125**
Strain, Herb A Kansas City	**125**
Stromberg, Brent V St. Louis	**190**
Thompson, Frederick E Liberty	**050**
Tobin, Gregory A Cape Girardeau	**042**
Towle, Dana R Kansas City	**050**
Wall, Norman R Springfield	**082**
Walton, Patrick J Kansas City	**125**
Weeks, Paul M St. Louis	**190**
Winsky, Arlen D Springfield	**082**
Young, Robert A Chesterfield	**190**
Young, Vernon L St. Louis	**190**

Psychiatry (P)

Ajans, Zaki A Mexico	**014**
Aleksander, Bernardo G El Paso, TX	**190**
Allison, James B Springfield	**082**
Anderson, Thomas R Columbia	**026**
Baird, Keim L St. Charles	**189**
Balcer, Charlotte M Jefferson City	**058**
Bartulica, Nicholas St. Joseph	**030**
Batterson, James R, Jr. Kansas City	**125**
Beitman, Bernard D Columbia	**026**
Biggs, John St. Louis	**190**
Bright, James E Springfield	**082**
Bronson, Shael S St. Louis	**190**
Calabria, Rafael Nevada	**214**
Calhoun, Joshua W St. Louis	**190**
Callahan, Joseph D St. Louis	**190**
Callaway, Jo J Kansas City	**125**
Choi, Sei Young St. Charles	**189**
Cole, Sherman W Kansas City	**125**
Corvalan, Juan C St. Louis	**190**
Crane, John B Washington	**074**
Croughan, Jack L St. Louis	**190**
Crumpacker, Margaret St. Louis	**190**
Curry, D. Troy St. Louis	**190**
Davis, Mary A St. Louis	**190**
Dewald, Paul A St. Louis	**190**
Dewein, Edward G St. Louis	**190**
Dick, M. Marga Ashland	**026**
Dos Santos, Enrique Columbia	**026**
Dowell, George H St. Louis	**190**
Edmisten, Jack Nevada	**125**
Efstathianos, Kimon Belleville, IL	**190**
Eppright, Thomas D Columbia	**026**
Finn, Murray E St. Louis	**190**
Frazier, Robert E Columbia	**026**
Garcia, Eduardo L St. Louis	**190**
Gavankar, Sharad S Joplin	**102**
Glazzard, Charles D Springfield	**082**
Glenn, Theodore J Cape Girardeau	**042**
Gonzalez, Alicia D St. Louis	**190**
Grossberg, George T St. Louis	**190**
Guze, Samuel B St. Louis	**190**
Hagen, Duane Q St. Louis	**190**
Hartnett, Anna E St. Louis	**190**
Hartnett, Thomas D St. Louis	**190**
Hay, Donald P St. Louis	**190**
Hicks, Frederick G St. Louis	**190**
***Hogan, Patricia E** St. Joseph	**030**
Holemon, R. Eugene St. Louis	**190**
Hornstra, Robijn K Kansas City	**125**
Houghton, Howard L Kansas City	**125**
Hucke, Samuel T, III Kansas City	**125**
Hudgens, Richard W St. Louis	**190**
Hughes, Derek Columbia	**026**
Irvin, Wm M St. Louis	**190**
Jones, Georgia A St. Louis	**190**
Jones, Laird E Springfield	**082**
Kamath, K.P.S. Cape Girardeau	**042**
Katf, Nicola Y N. Kansas City	**050**
Khan, Khawla B St. Louis	**002**
Khojasteh, Saaid St. Louis	**002**
Kitchin, Winston H St. Louis	**190**
Kleinschmidt, Donn C St. Louis	**190**
Knowles, R. Raymond St. Louis	**190**
Krojanker, David N St. Louis	**190**
Krojanker, Rolf J St. Louis	**190**
Kuhn, Lawrence F Bridgeton	**190**
Kulak, Gary St. Louis	**190**
Kulick, Eric M Prairie Village, KS	**125**
Lamb, Wanda St. Louis	**190**
LeFevre, Philip J Springfield	**082**
Lindgren, Carleton J Independence	**125**
Lipschitz, Ervin St. Louis	**190**
Liss, Jay L St. Louis	**190**
Lucas, Thomas G St. Louis	**190**
Lyskowski, John C Jefferson City	**058**
Malmberg, Virgil L Chesterfield	**190**
McAfee, Gordon Springfield	**082**
McGahee, C. Leon St. Louis	**190**
Mendez, Maria A Springfield	**082**
Meyer, Jay L St. Louis	**190**
Meyers, Robert W St. Louis	**190**
Milgram, Byron A Kansas City	**125**
Miller, Jule P St. Louis	**190**
Miller, Pamela S Rolla	**135**
Monroe, C. Dean Columbia	**026**
Moran, Thomas M St. Louis	**190**
Moritz, K. Lynne St. Louis	**190**
Munro, John S Kansas City	**125**
Nieuwenhuizen, Maarten Columbia	**026**
Nowotny, Thomas J St. Louis	**190**
Ohlms, David L St. Louis	**190**
Othmer, Ekkehard Kansas City	**050**
Packman, Paul St. Louis	**190**
Parks, Joseph J Jefferson City	**026**
Parwatikar, Sadashiv D St. Louis	**190**
Peterson, Stephen E Kansas City	**125**
Pew, Becky A St. Louis	**190**
Pickens, Andrew T St. Louis	**190**
Post, Stephen L St. Louis	**190**
Pribor, Elizabeth F Chesterfield	**190**
Pro, John D Kansas City	**125**
Rankin, Diane St. Louis	**190**
Ratnam, Dasari V Kansas City	**125**
Ray, Larry D Olathe, KS	**125**
Reddy, Agara S Columbia	**026**
Ricci, Walter F Shawnee Mission, KS	**125**
Richardson, Thomas F St. Louis	**190**
Rizzo, Adolfo E St. Charles	**190**
Robinson, Gordon H St. Louis	**190**
Rosenthal, Randall St. Louis	**190**

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Ryall, Jo-Ellyn M	190	St. Louis
Sabet, Abdollah A	190	Ballwin
Saghir, Marcel T	190	St. Louis
Schmitz, John M	125	Kansas City
Schwarz, Luis H	190	St. Louis
Segraves, Steven D	125	Kansas City
Sheffner, Paul W	190	St. Louis
Shen, Winston W	190	St. Louis
Shopper, Moisy	190	St. Louis
Simmons, Donald D	125	Kansas City
Simon, Nathan M	190	St. Louis
Snow, Emasue	082	Springfield
Soltys, Stephen M	026	Jefferson City
Soorya, Narendir T	190	St. Louis
Stewart, Harry A	125	Shawnee Mission, KS
Stillings, Wayne A	190	St. Louis
Tilzer, Seth	190	Florissant
True, James D	050	Kansas City
Trugly, Edith S	190	St. Louis
Valera, Salvador S	030	St. Joseph
Vandivort, Paul M, Jr.	190	St. Louis
Viamontes, Jorge A	190	St. Louis
Vickar, Garry M	190	Florissant
***Williams, Robert J**	030	St. Joseph
Wilson, Roy E	082	Springfield
Wolff, Harold D	190	St. Louis
Yates, John M	058	Jefferson City

Public Health (PH)

Biery, Richard M	125	Kansas City
Kimmey, James R	190	St. Louis

Pulmonary Disease (PUD)

Beller, Thomas A	125	Kansas City
Bittle, Bradley K	042	Cape Girardeau
Brabson, John H	082	Springfield
Brischetto, Michael J	190	St. Louis
Brook, Charles J	125	Kansas City
Devins, George S	125	Kansas City
Goheen, John R	125	Kansas City
Grimm, Mark E	082	Springfield
Hargis, James L	082	Springfield
Harrison, Garth F	125	Kansas City
Heinz, George	082	Springfield
Khan, Khalid I	042	Cape Girardeau
King, John V, Jr.	190	Ballwin
Lampton, Lawrence M	026	Columbia
Lerner, Scott A	125	Kansas City
Mahmoud, Said F	125	Kansas City
Reddy, Anchala N	206	West Plains
Scacewater, Rick	102	Joplin
Schlozman, Danl L	125	Kansas City
Siler, Thomas M	189	St. Charles
***Thomas, Norvin E**	014	Mexico
Wiant, James R	190	St. Louis
Wood, John A	190	Chesterfield

Radiation Oncology (RO)

Baglan, Robert J	190	St. Louis
Bedwinek, John M	190	St. Charles
Bryer, Mark P	026	Columbia
Butler, David F	190	Chesterfield
Cozad, Scott C	125	Kansas City
Devineni, V. Rao	190	Bridgeton
Fu, Anna L	190	St. Louis
Garcia, Delia M	190	St. Louis
Hanes, Lily A	190	Golden Eagle, IL
Lee, Fransiska A	190	St. Louis
Lin, Hsiu-San	190	St. Louis
Massey, Vickie	125	Kansas City
McDonough, Michael	002	St. Louis
Mill, William B, Jr.	190	St. Louis
Miller, Joseph P	042	Cape Girardeau
Morrison, Richard A	125	Independence
Myers, Duane E	102	Joplin
Nigh, Stephen S	125	Kansas City
Pacheco, Jose M	082	Springfield
Perez, Carlos A	190	St. Louis
Robinow, Jay S	125	Kansas City
Roy, Tapankumar S	190	St. Louis
Simpson, Joseph R	190	St. Louis
Smalley, Stephen R	125	Kansas City
Sutphen, Eric J	190	St. Louis
Walz, Bruce J	190	St. Louis
Zivnuska, Frederick R	190	St. Louis

Radiation Therapy (TR)

Abadir, Rushdy	026	Columbia
Alcancia, Elpidio Y	082	Springfield
Boles, Murray	026	Columbia
Chaudhury, Triptesh K	002	Overland Park, KS
Cohen, Joel N	082	Springfield
Murrell, H. Jerry	026	Columbia
Paradelo, Jorge C	125	Kansas City
Rogers, Joseph Drewry	082	Springfield
Throne, Ben J	125	Kansas City
Westgate, Steven J	026	Columbia

Radiology (R)

Abodeely, Daniel A	190	St. Louis
Al-Aly, Robert M	190	Chersterfield
Albritton, Michael A	082	Springfield
Anderson, D. Claire	190	St. Louis
Bardsley, John L	190	St. Louis
***Bartow, John H**	030	St. Joseph
Baskurt, Mehmet V	034	Poplar Bluff
Baula, Armindo G	190	St. Louis
Berni, Anthony A	190	St. Louis
Blackwell, Charles W	026	Columbia
Busse, Paul P	190	St. Louis
Campbell, William S, Jr	042	Cape Girardeau
Carls, Garry L	190	Imperial
Cline, Patricia W	125	Kansas City
Clouse, John W	082	Springfield
Cohen, Edward	190	St. Louis
Colbert, Robert S	202	Sikeston
Cook, Marvin	190	St. Louis
Corder, Patricia G	190	St. Louis
Courter, Larry P	058	Osage Beach
Crotty, John P	190	St. Louis
Dehner, Jonathan D	190	St. Louis
DeMotte, Jeanne M	118	Richmond
Diemer, David P	190	St. Louis
Diemer, Peter A	190	St. Louis
***Ditzel, Douglas W**	102	Joplin
Dixon, G. David	125	Kansas City
Egan, Thomas F	190	St. Louis
Elwing, Terry J	026	Columbia
Ely, Norman B	082	Springfield
Francisco, Dominic S	190	St. Louis
Gates, Mark L	042	Cape Girardeau
Gerdes, K. Eric	082	Springfield
Gilula, Louis A	190	St. Louis
Goodman, Douglas E	082	Springfield
Gregston, J. Leon	082	Springfield
Gubin, Barry A	125	Kansas City
Gujarati, Subhash B	034	Poplar Bluff
Gustafson, Jon E	125	Lee's Summit
Habert, Edward R	190	Chesterfield
Hassien, Joel D	150	Hannibal
Hawkins, Calvin D	082	Springfield
Hesker, Albert E	190	Chesterfield
Higgins, Michael D	042	Cape Girardeau
Hoskins, R. Bruce	125	Kansas City
Jablonski, Raymond C	190	St. Charles

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Jamroz, Greg A	074	Washington
Judd, Jeffrey B	190	St. Louis
Kays, Kenneth M	046	Osage Beach
Kester, Nathan L	082	Springfield
Kim, Stanley W	190	St. Louis
Kotner, Lawrence M, Jr.	190	St. Louis
Krahn, Henry C	082	Springfield
Krain, Samuel	190	St. Louis
Kunz, Stephen R	125	Overland Park, KS
LacKamp, Robert J	030	St. Joseph
Lambie, Rodger W	125	Kansas City
Lang, John J	190	St. Louis
Leary, Daniel J	190	St. Louis
Lenzenhuber, Karl J	074	Washington
Link, Alexander J	190	St. Louis
Litzow, Peter L	190	St. Louis
Logie, Macdonald B	190	St. Louis
***Lovern, Royce E**	074	Washington
MacDonald, Robert R, Jr.	190	St. Louis
MacNaughton, Robert A, II	050	Liberty
Mais, Thomas E	125	Shawnee Mission, KS
McCown, Allan H	190	St. Louis
Miller, Geoffrey W	190	St. Louis
Nemec, Edward S	190	St. Louis
Nepute, James A	190	St. Louis
Niemeyer, John H	190	St. Louis
Noh, Kyung M	026	Columbia
O'Brien, Edward J, Jr.	190	St. Louis
Orsay, Paul K	190	Chesterfield
Paskar, Larry D	190	Chesterfield
Pepper, Edward G	190	St. Louis
***Pfautsch, Mark L**	042	Cape Girardeau
Phelan, Christie B	125	Kansas City
Phelan, David	125	Independence
Rall, Kenneth L	026	Independence
Reh, Thomas E	190	St. Louis
Rezvani, Laghaieh	202	Sikeston
Riaz, M. Afzal	174	Ste. Genevieve
Rozen, Jay I	125	Kansas City
Saboeiro, Gregory R	002	St. Louis
Savci, Hasan D.	190	St. Louis
Schmidt, Dennis A	190	St. Louis
Schulz, Richard C	190	St. Louis
Shields, John B	190	St. Louis
Shore, Jeffrey L	102	Joplin
Smeltzer, Frederick M	120	Lake Ozark
Smith, Robert W	190	Chesterfield
Solomon, Steven L	190	St. Louis
Spalding, Donald G	190	St. Louis
Staab, Gerald E	125	Kansas City
***Stucka, John , Jr.**	102	Joplin
Tailor, Chandrakant C	190	St. Louis
Tellerman, Barbara J	026	Columbia
Thompson, Robert F	125	Kansas City
Trevor, Richard P	125	Kansas City
Verde, Julian N	190	St. Louis
Vijungco, Jose G	190	St. Louis
***Weiss, Randy B**	102	Joplin
Weyman, Philip J	190	Chesterfield
Williams, Craig W	042	Cape Girardeau
Zeigler, Joseph M	190	St. Louis

Reproductive Endocrinology (REN)

Lyles, Rodney	125	Overland Park, KS
Starks, Gregory C	125	Kansas City
Zamah, Nezaam M	125	Kansas City

Rheumatology (RHU)

Armstrong, Stephen D	082	Springfield
Auclair, Ronald J	190	St. Louis
Braun, Alan L	058	Jefferson City
***Bronson, Wendell D**	030	St. Joseph
Fischbein, Lewis C	190	St. Louis
Ghosh, Sanjay	074	Washington
Huston, Kent A	125	Kansas City
Kincaid, William L	190	St. Louis
Lamonte-Jost, Daniel J	026	Columbia
Schwartz, Howard R	082	Springfield
Taylor, Philip W	042	Cape Girardeau

Thoracic Surgery (TS)

Baumgartner, Norbert E	042	Cape Girardeau
Cardone, John C	125	N. Kansas City
Coordes, Cordie C	190	Chesterfield
Cox, James L	190	St. Louis
Daily, Bill B	002	St. Louis
Early, Gerald L	030	St. Joseph
Eisenberg, Steven B	190	Chesterfield
Gallion, Terry L	125	Prairie Village, KS
Garrett, Ted E	190	St. Louis
Graham, Joseph E	190	St. Louis
Gurucharri, Vincent P	026	Columbia
Huddleston, Charles B	190	St. Louis
Judd, Donald R	190	St. Louis
Kaiser, George C	190	St. Louis
Killen, Duncan A	125	Kansas City
Kouchoukos, Nicholas T	190	St. Louis
Kraeger, Russell R	190	St. Louis
Leidenfrost, Ronald D	190	Chesterfield
Marbarger, John P, Jr.	190	St. Louis
McDonald, Herbert L	066	Bolivar
Murphy, J. Peter , Jr.	190	St. Louis
Murphy, Michael C	190	St. Louis
O'Sullivan, Daniel F	190	St. Louis
Patterson, Alec	002	St. Louis
Piehler, Jeffrey M	125	Kansas City
Pinkerton, Joe A, Jr.	125	Kansas City
Ramsey, J. Darryl	042	Cape Girardeau
Reinhardt, J. Robert R	125	Kansas City
Robison, Paul D	102	Joplin
Roper, Charles L	190	St. Louis
Ruess, Robert W	042	Cape Girardeau
Sasser, William F	190	St. Louis
Shaw, Richard C	190	St. Louis
Stephenson, Hugh E	026	Columbia
Sundaresan, Sudhir	002	St. Louis
Sundt, Thoralf M	002	St. Louis
Van Way, Charles W, III	125	Kansas City
Wathanacharoen, Suchint	125	Kansas City

Urology (U)

Abercrombie, Keith J	125	Kansas City
Ahmann, Thomas M	014	Mexico
Albani, Frank J	050	Liberty
Aldridge, George A	034	Poplar Bluff
Apte, Sunil M	074	Washington
Avallone, Anthony N	082	Springfield
Biber, Robert J	125	Independence
Bigg, Steven W	190	St. Louis
Blades, Ross D	082	Springfield
Blath, Richard A	190	St. Louis
Brehm, G. Scott	102	Joplin
Brodkey, Mark J	125	Kansas City
Bussmann, Donald W, Jr	082	Springfield
Carpenter, James L	189	St. Charles
Chehval, Micheal J	190	St. Louis
Cockrell, Steven N	150	Hannibal
Davis, Bradley E	125	Overland Park, KS
DeGuerre, Ronald K	190	Chesterfield
Deleste, Carlos J	106	Festus
Denes, Bela	190	Bridgeton
Dresner, Steven M	026	Columbia
Ellis, Harry L	082	Springfield

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Name	City	Code
Emeran, George J	St. Louis	190
Falzone, John J	Jefferson City	058
Farber, Barry S	Springfield	082
Fathman, Anthony E	Chesterfield	190
Feit, Robert M	St. Louis	190
Felker, J. Russell	Cape Girardeau	042
Foster, R. Steve	Sedalia	178
Frogge, Jim D	Joplin	102
Gelstein, Laurence D	St. Louis	190
Gonzales, Jose H	Perryville	174
*Hall, John P	Cape Girardeau	042
Hardy, David A	St. Louis	190
Harrison, Winston E	Columbia	026
Hawatmeh, Abraham S	St. Louis	190
Herrick, Thomas B	Kansas City	050
Houttuin, Erik	Washington	074
Itoku, Kendall	Chesterfield	190
Johnson, Jeffrey R	Springfield	082
Klein, Saul J	St. Louis	190
Koonce, John P	Jefferson City	058
Kozminski, Mike	St. Joseph	030
Kurtz, Karl J	Kansas City	125
Lentz, Harold C, Jr.	Independence	125
Lierz, Mark F	St. Joseph	030
Lovinggood, J. Perry	Bridgeton	190
Madduri, Sivaprasad D	Poplar Bluff	034
Marcus, Michael D	St. Louis	190
McCanse, Lynn R	N. Kansas City	050
Milne, Jay L	Springfield	082
Mitchell, John D	Kansas City	125
Montie, Joseph E	Columbia	026
Morgan, Willy J C	E. St. Louis, IL	190
Myers, George H	Kansas City	125
Neuman, Neal	St. Louis	190
Nicolai, Charles H	St. Louis	190
Parres, Jeffrey A	St. Louis	190
Partamian, Krikor O	St. Joseph	030
Pearson, Thomas C	Springfield	082
Perinetti, Enrique P	St. Louis	190
Reddy, Abbiah N	Poplar Bluff	034
Ross, Gilbert , Jr.	Columbia	026
Saha, Nitai C	St. Louis	190
Scheibe, Robert G	St. Louis	190
Schmidt, Jerome H	Jefferson City	058
*Schoenfeld, Roger H	Joplin	102
Scully, Thomas F	St. Louis	190
Severance, Michael S	Jefferson City	058
Shah, Jitendra P	St. Louis	190
Shands, Courtney , III	St. Louis	190
Stanley, Brad K	Independence	125
Sunshine, Herbert	St. Louis	190
Teague, J. Lynn	Columbia	026
Terry, James F	Springfield	082
Thompson, Paul D	Cape Girardeau	042
Torrence, Ralph J	Chesterfield	190
Walters, Frederick P	St. Louis	190
Wan, Shaw P	Rolla	135
Weaver-Osterholtz, Dana J	Columbia	026
Weide, Allan R	N. Kansas City	050
Weinberger, Phillip C	Sedalia	178
Weinstein, Stephen H	Columbia	026
Wilson, William T	Independence	125
Wise, Morris F	Kansas City	125

Vascular Surgery (VS)

Name	City	Code
Adams, John G	Cape Girardeau	042
Auer, Arthur I	St. Louis	190
Barbee, Charles W	Columbia	026
Cates, Joe A	Kansas City	125
Del Santo, Peter B	Columbia	026
Fogartie, James E, Jr.	Kansas City	050
Higgins, Edward F, JR	Kansas City	125
Hurley, Joseph J	St. Louis	190
Jacobs, Donald L	St. Louis	002
Nichols, W. Kirt	Columbia	026
Ostrow, Bridget F	Cape Girardeau	042
Silver, Donald	Columbia	026
Stark, Karl R	Kansas City	125
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042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
074	Franklin-Gasconade-Warren
078	Grand River
082	Greene
086	Henry
102	Jasper-Newton Metropolitan
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metropolitan Medical Society of Greater Kansas City
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
189	St. Charles-Lincoln
190	St. Louis Metropolitan
198	Saline
202	SEMO
206	South Central
208	Tri-Lakes
210	Webster
214	West Central
215	Resident Physician Section

Medical Student Sections

216	St. Louis University
218	University of Missouri - Columbia
220	University of Missouri - Kansas City
222	Washington University

Primary Specialty Codes

A	Allergy
AI	Allergy & Immunology
AN	Anesthesiology
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
CHN	Child Neurology
CHP	Child Psychiatry
CLP	Clinical Pathology
CRS	Colon & Rectal Surgery
CCM	Critical Care Medicine
D	Dermatology
DR	Diagnostic
EM	Emergency Medicine
END	Endocrinology
FPS	Facial Plastic Surgery
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GS	General Surgery
GYN	Gynecology
HEM	Hematology
HNS	Head & Neck Surgery
ID	Infectious Diseases
IM	Internal Medicine
MFM	Maternal & Fetal Medicine
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NS	Neurological Surgery
NM	Nuclear Medicine
NR	Nuclear Radiology
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OS	Other
OTO	Otolaryngology
PTH	Pathology
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PDR	Pediatric Radiology
PDS	Pediatric Surgery
PM	Physical & Rehabilitation Medicine
PS	Plastic Surgery
P	Psychiatry
PH	Public Health
PUD	Pulmonary Disease
RO	Radiation Oncology
TR	Radiation Therapy
R	Radiology
REN	Reproductive Endocrinology
RHU	Rheumatology
TS	Thoracic Surgery
U	Urology
VS	Vacular Surgery

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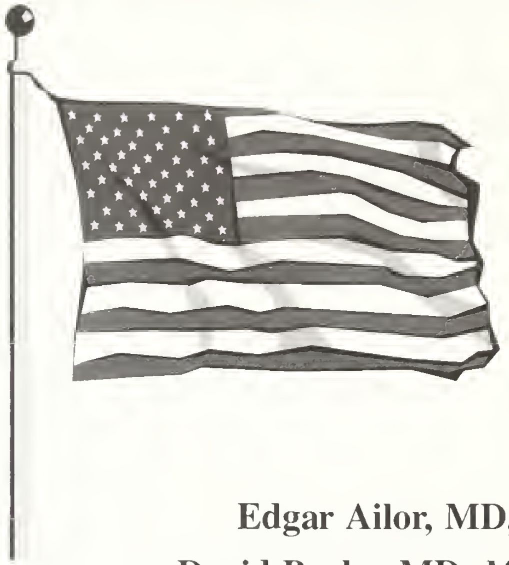

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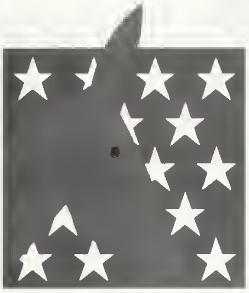

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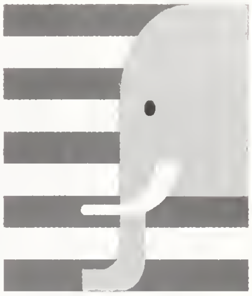

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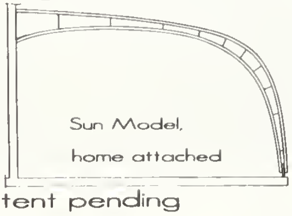

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MISSOURI MEDICINE

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On the Cover: "Fall Shadows" 24" x 32" acrylic painting by Joseph Orr. Artists Joseph and Rita Orr own and operate Orr Studios in Osage Beach, Missouri.

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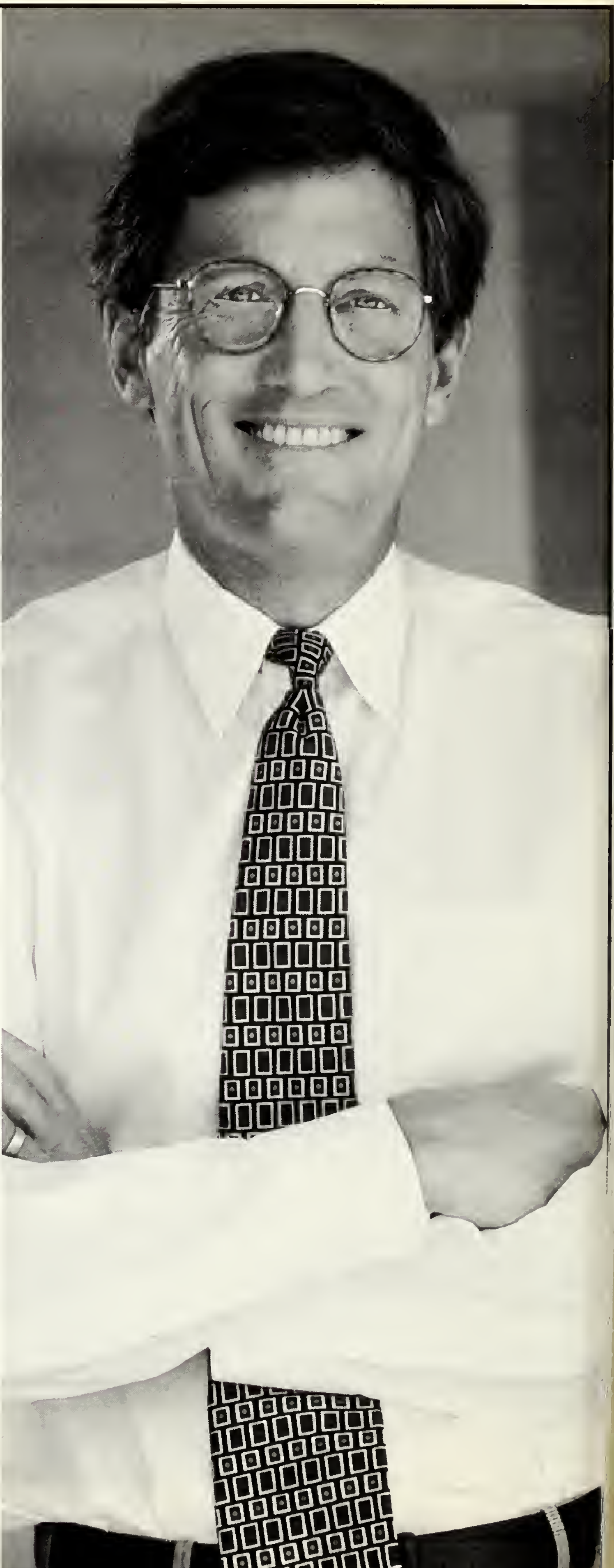


MSMA: The Thomas Tour

J. Regan Thomas, MD, Editor

I was recently at the MSMA office in Jefferson City and again reminded of what a fine facility we have there. Of course as with any organization, it's the people inside and the work being done, and not the bricks and mortar that make the biggest difference for the group. That being said, the tangible images that represent the organization and its membership are still important and can act as one ingredient of the institutional glue that binds the members and professional staff.

Very few of our members have actually taken the opportunity to visit our headquarters. You will be very proud of what you see and I am confident you will agree that it represents our association in a superb fashion. MSMA headquarters is located in a historic building built in 1871 by B. Gratz Brown, the 20th Governor of Missouri. It is situated directly across the street from the Governor's Mansion and near the Missouri River. It sits just two blocks away from the Capitol Building and near all the state administrative buildings so our staff is immediately available to interact with legal, regulatory and legislative issues.

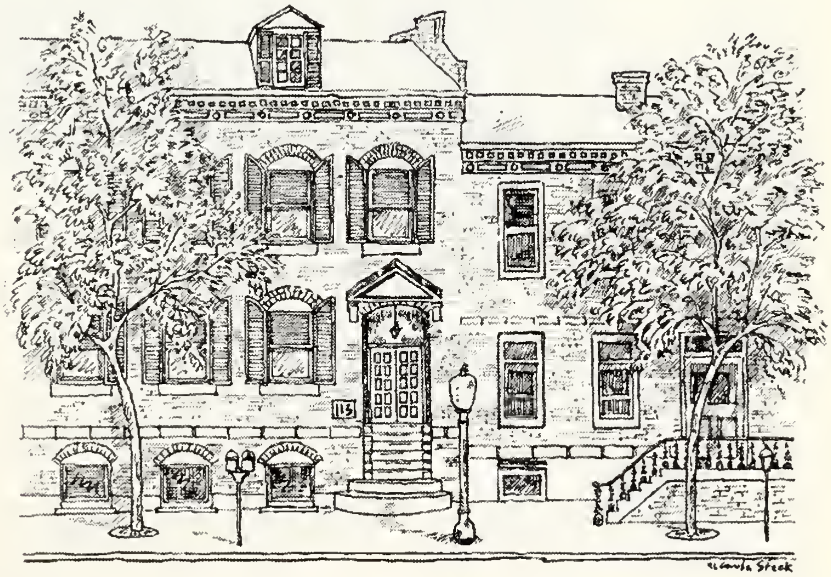
The remodeled building itself is elegant and sophisticated in appearance. Architecturally it presents the proper forum and image for a respected, serious-minded organization like MSMA.

Our headquarters is in the heart of the Capital City. You will indeed be proud when you have the opportunity to visit. Inside, you will be pleased to find friendly, helpful staff who are as delighted that you decided to visit the office, as you will be that you did.

Here is a suggestion for an interesting and educational day at the MSMA headquarters. First find the headquarters office at 113 Madison Street. Every time I have visited I found a parking spot right in front on Madison. If not, there is a public parking lot just around the corner. If you park on the street, be sure to use your emergency brake. Jefferson City is much like San Francisco in terms of the hills and more than one car has ended up as an unplanned roller coaster through the years.

Walk on into the office and introduce yourself. Ask for the "mini-tour" and someone will show you around. You will be impressed.

Continued on page 564



History of 109-111-113 Madison

Calvin Gunn came to Jefferson City in 1826 from St. Charles and established the newspaper, *Jeffersonian Republican*. In 1837 he purchased the property know known as 111-113 Madison upon which was situated a two-story brick tenement building for his printing and newspaper business and various tenants. In 1839, he built his family residence at 109 Madison. He was appointed state printer by the legislature in December 1826.

Mr. Gunn died August 23, 1861 and his wife, Elizabeth, inherited his estate. Elizabeth Gunn, Sr. died in September 1871, and her will devised to her youngest daughter, Elizabeth, the real property now known as 109-111-113 Madison Street. Governor B. Gratz Brown, husband of Mary Hanson Gunn Brown, son-in-law of Mrs. Elizabeth Gunn, Sr. was made trustee of the properties "for the sole use and benefit of my daughter Elizabeth."

The present row house numbered 109-111-113 Madison was built in 1871, presumably under the direction of Governor Brown, who was inaugurated January 1871 for a two-year term.

Shortly after the inauguration, Mrs. Brown, who was expecting their sixth child, returned to the family home in St. Louis and to the Brown farm near Ironton. That Fall, several members of the Brown family became ill at the farm, and Mrs. Calvin Gunn, widowed mother of Mary Gunn Brown, went to care for them. Mrs. Gunn died there in September. Her funeral at the Governor's Mansion at the corner of Madison and Capitol Ave., was the last public function before demolition of the building in October 1871.

Work on the present Executive Mansion was begun in May 1871, and the Brown family moved in late December. Upon completion of his term in office, the family returned to St. Louis in January 1873, and Governor Brown practiced law until his death in 1885.

On May 21, 1881, the property known as 109-111-113 Madison was sold at public venue at the Court House in St. Louis to satisfy the deed of trust in the amount of $4,000. From that time on the three sections were always sold separately to different buyers and used for private residences, rooming and apartment houses, and various businesses.

109 Madison was sold to the Cole County Historical Society in 1946. The Missouri State Medical Association bought 113 Madison in 1973.

Information provided by the Cole Co. Historical Society.

Continued on page 563

Next on the Thomas Tour of Jefferson City is a visit to the train station. It is just a few minutes walk (downhill) from MSMA and an interesting as well as historic site. From there walk up to one of the many restaurants in the area for lunch or snacks.

Later its just a short distance to the Capitol Building. The rotunda and building architecture are interesting in their own right, but don't miss the museum downstairs. As my family will confirm, I'm a museum addict so my opinion is no doubt biased, but the displays are great and if you have not seen them it's worth the time to browse. While you are there, check the directory of the office location of your state senator and representative and set up a visit time in advance. In fact, I'm sure someone can do that for you while you're at the MSMA.

The Governor's Mansion is just next door. There are specific times for visiting inside, but just walking around the outside and seeing the grounds is worthwhile. This brings you back to the MSMA headquarters across the street and your car.

The final stop on this tour is too far to walk (especially in hilly Jefferson City). Get in your car and drive the short distance to the Central Dairy. Here you'll find the best ice cream around. In fact, I'm absolutely sure that the hot fudge sundae (pecans at no extra charge) is the world's best treat for the money. Best of all, you can soothe your conscience with the knowledge of all the exercise you got while visiting the Capital City's points of interest.

We have a lot to be proud of as Missourians and especially as MSMA members. I hope you take my suggestions and make a visit. Don't forget to ask for extra hot fudge. **MoMed**

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Treatment by Neglect

John A. Carrier, MD, Ballwin, Missouri

Let's call him Claude. That wasn't his real name. He was a patient of mine back in the Forties, and he had a drinking problem. He and his wife had been trying to deal with this problem for many years. Like many others, Claude periodically would be in a prolonged sober phase, and be a charming and likeable soul. Also, had a very responsible job as a trouble shooter for the local gas company. This position was of great concern to both me and his wife. Working with leaky gas pipes in residential and industrial areas could be disastrous if he started "hitting the booze" some Monday morning.

Luckily, Claude had some insight into his difficulty. He called my office for a special appointment and came in with his long-suffering wife. He said he had started "sampling the sauce" and was afraid he might be heading for a real binge. He wanted to be hospitalized and get off the "hootch" before he was in serious trouble.

At the time the only place I could personally hospitalize that type of patient was the old Missouri Pacific Hospital on South Grand in St. Louis. With his apparent good control and insight I decided to put him on a general medical floor. The other alternatives were two or three small locked rooms. These were more like jail cells – certainly appropriate for alcoholics with DT's or the "screaming willies!"

Claude and his wife were pleased with his semi-private room. I checked him over, wrote up his history and physical, and jotted down some orders. At that time in my practice I was extremely busy. I was admitting patients at three different hospitals; had a private practice office, and a part-time assignment in the Mo Pac outpatient clinic.

I carried a small pocket notebook which I kept a record of my hospital inpatients. This would help me to remember whom to see daily on my rounds. I always had the fear of forgetting someone. Well, I had forgotten to put Claude's name in my notebook, and didn't visit him for three days!

On the fourth day the head nurse said, "When are you going to see Claude again?" I replied, "Oh my gosh, I plain forgot him!" As I walked to his room I thought... "What am I going to say to this poor man who volunteered to enter the hospital, and I have strictly neglected him?"

Before I could say anything, he greeted me with a smile and said, "Doc, I'm sure glad to see you. I know you have been disgusted with me by my repeat drinking deals, and I just figured part of your treatment was not seeing me here for a few days."

Treatment by neglect had not been my intention, but it seemed to work with Claude. The remainder of the time in the hospital I saw him daily – sometimes twice. He did well for many months. Unfortunately, I lost track of him when I left private practice for a full-time job. As for his gas company duties – I never saw his name connected to any explosions described on TV or in the newspapers. MoMed

Radiology Quiz #7

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

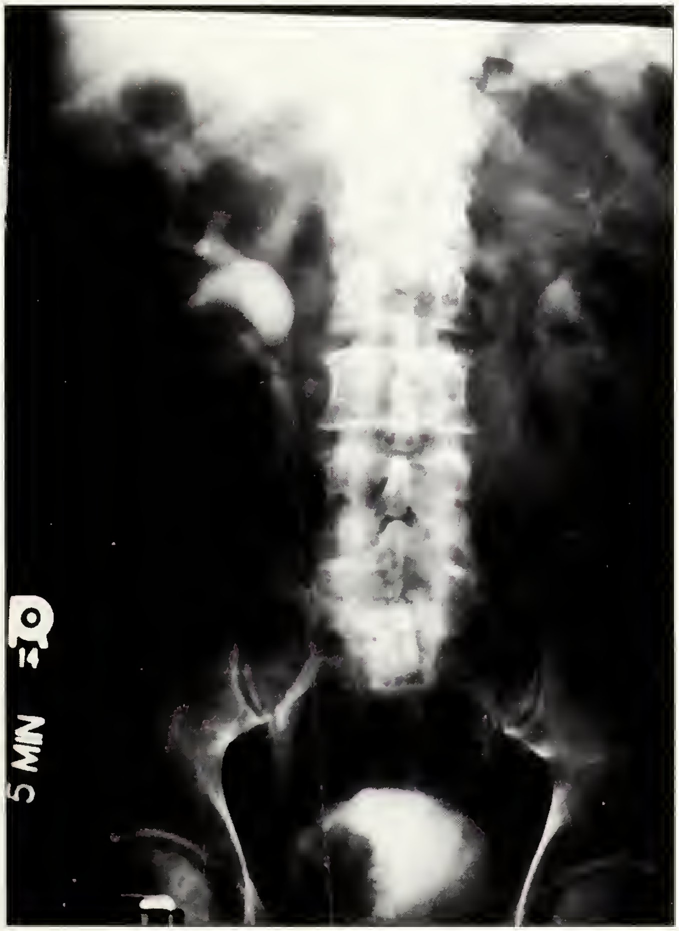


Figure 1

A 71-year-old man presented to the clinic with a one week history of painless gross hematuria. As part of the workup, an intravenous urogram was performed, with a representative film submitted (fig. 1).

What is the diagnosis?

a. bladder calculus

b. renal cell carcinoma

c. transitional cell carcinoma

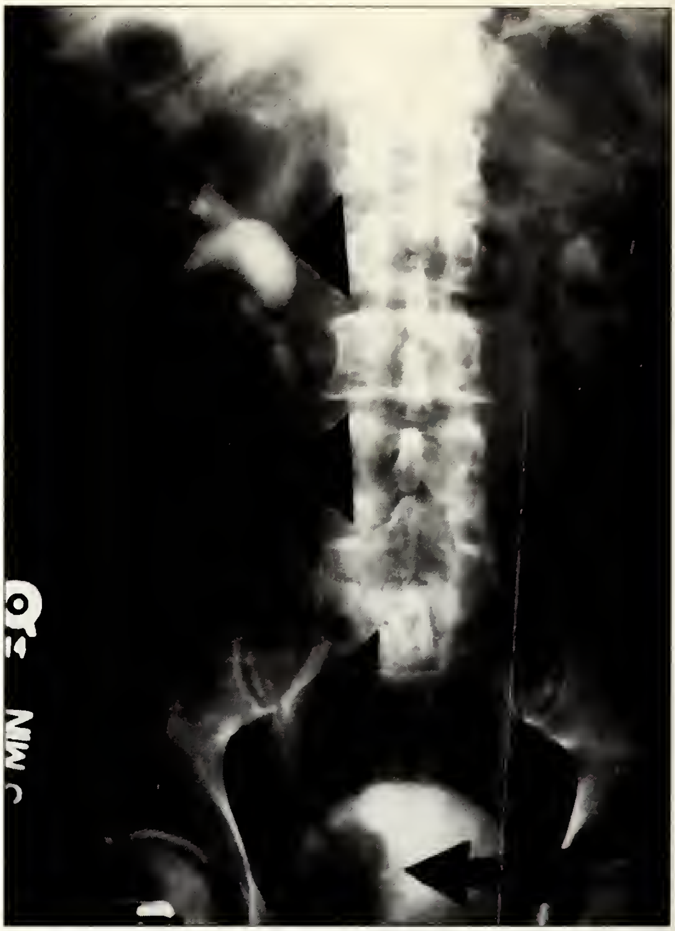
d. blood clot in bladder

(See answer on next page.)

Radiology Quiz Answer

**The Radiology Quiz question
is located on the previous page.**

ANSWER:
c. Transitional cell carcinoma of bladder.



Repeat Figure 1

The correct diagnosis is C, transitional cell carcinoma of the bladder. The film from the intravenous urogram (repeat Fig. 1) shows a lobulated filling defect in the right side of the bladder (arrow). There is also moderate dilatation of the right ureter and renal collecting system (arrowheads) indicating that the mass is causing obstruction at the distal end of the ureter. The renal collecting systems and ureters appear otherwise normal, with no renal mass identified.

Cystoscopic biopsy showed papillary transitional cell carcinoma of the bladder with muscular wall invasion. Following diagnosis, imaging staging is usually indicated to rule out extravesical spread of neoplasm prior to attempted surgical treatment. Computerized tomography has been the most commonly used staging modality, although magnetic resonance imaging (MRI) is becoming more widely used for staging due to excellent soft tissue resolution. Transurethral ultrasonography has also shown promise.

Transitional cell carcinoma is the most common malignant neoplasm of the bladder, accounting for 90% of cancers. Five percent of bladder cancers are squamous cell carcinomas, and 5% are mixed. Patients usually present with painless gross hematuria.

Option A, bladder calculus is unlikely due to the irregular margins of the lucent filling defect seen in the test case. Bladder calculi are usually smooth and opaque. Also, a calculus is the bladder would probably not account for unilateral ureteral obstruction.

Option B, renal cell carcinoma is incorrect since the mass is clearly seen to lie in the bladder. The renal collecting system shows no evidence of displacement or distortion by mass.

Option D, blood clot in the bladder would be unlikely to cause obstruction of the ureter. However, blood clots anywhere in urinary tract can cause filling defects which may be indistinguishable from stone or neoplasm. Clots may reveal themselves by moving or changing in size or shape on additional views or follow-up films.

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Membership Notes

Richard H. Gelberman, MD, Fred C. Reynolds Professor and head of the Department of Orthopaedic Surgery at Washington University School of Medicine, has received a four-year grant to study flexor tendon healing. This grant is a continuation of earlier funding from the National Institute of Arthritis and Musculoskeletal and Skin Diseases at the National Institutes of Health. Dr. Gelberman is researching a new repair method to enable aggressive rehabilitation immediately following surgery and also the healing process on a cellular level.

Steve M. Gnatz, MD, Associate Professor and Chair of Physical Medicine and Rehabilitation at the University of Missouri-Columbia Howard A. Rusk Rehabilitation Center, presented a program review of the Missouri Arthritis Rehabilitation Research Training Center (MARRTC) for the National Institute of Disability and Rehabilitation Research (NIDRR) in Washington, D.C. this past spring. He also acted as an oral board examiner for the certification of candidates by the American Board of Electrodiagnostic Medicine at the April board exams in Chicago, IL, and on the May Psychiatric Evaluation and Management of Pain at the American Board of Physical Medicine & Rehabilitation (ABPM&R) Board Exams in Rochester, MN. Dr. Gnatz has begun work as an author for the ABPM&R's 1998 Pain Rehabilitation Study Guide.

Richard Hellman, MD, and **Howard Rosen, MD,** private practice physicians specializing in endocrinology and diabetes in Kansas City, presented their poster entitled, "Reducing Mortality in IDDM and NIDDM with a Comprehensive Diabetes Program" at the 56th Annual Scientific Sessions of the American Diabetes Association in June at San Francisco. Dr. Hellman also gave an oral presentation entitled, "Long Term Intensive Insulin Therapy in NIDDM is not Associated with Increased Cardiac Mortality" at the 10th International Congress of Endocrinology.

G. Robert Kletzker, MD, FACS, of St. Louis, Missouri, was a panel participant at the Second International Congress of Skull Base Surgery in San Diego, California in July. He was one of the participants in the international panel on *Avoidance of Complications in Skull Base Procedures - The Neurotologic Perspective.*

Willie E. Lawrence Jr., MD, FACC, FACP, a cardiologist practicing with Midwest Cardiology Associates in Kansas City, has been elected to a Fellow of the American College of Physicians (ACP), the society of internists. Election to Fellowship in ACP signifies high achievement in internal medicine, the specialty of adult medical care. Dr. Lawrence is also the newly-elected President of the Greater Kansas City Chapter of the American Heart Association.

MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to ***Missouri Medicine****, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

Susan E. MacKinnon, MD, has been named chief of the Division of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis. Dr. MacKinnon succeeds Paul M. Weeks, MD, previous professor and chief of the division for 25 years. Dr. MacKinnon joined the faculty in 1991 as professor of surgery in plastic and reconstructive surgery. She is known for her ground-breaking work in the area of peripheral nerve transplantation.

Mark Martin, MD, of Lee's Summit, was installed President of The Missouri Academy of Family Physicians during its annual meeting in June. Dr. Martin succeeds, **James Turner, MD,** of Washington, who stepped up to Chair of the Board of Directors of MAFP. Also installed were **Michael Munger, DO,** of Kansas City, as Secretary-Treasurer, and **Mike Wulfers, MD,** of Cape Girardeau as a director.

Jon Rupright, DO, Assistant Professor of Clinical Physical Medicine and Rehabilitation at the University of Missouri-Columbia Howard A. Rusk Rehabilitation Center, presented on the topics of "Low Back Pain Rehabilitation," "Head Injury in the Workplace," and "Myofascial Pain in the Injured Worker," at the St. Mary's Health Center Workman's Compensation Seminar held in Jefferson City.

Peter G. Smith, MD, PhD, of Midwest Otologic Group in St. Louis, was a guest lecturer at the 7th Annual Meeting of the American Society of Neurophysiologic Monitoring held in May at St.

Louis, Missouri. He presented, "Surgical Orientation to Cranial Nerve Monitoring in Lateral Cranial Base Surgery" during a symposium entitled "Cranial Nerve Monitoring." Dr. Smith also served as a member of international pediatric skull base and clival tumor panels and an instructor in an intensive practical course on skull base surgery at the combined 2nd International Skull Base Congress and the 7th Annual Meeting of the North American Skull Base Society. The meetings were held in San Diego, CA. Dr. Smith was also recognized for his effort as President of the North American Skull Base Society.

J. Regan Thomas, MD, Professor and Chair of the Department of Otolaryngology, Head and Neck Surgery, at Saint Louis University School of Medicine, will receive the 1996 John Dickinson Teacher Award from the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). The award is presented annually to an AAFPRS Fellow who has shared knowledge of facial plastic surgery with the effective use of audiovisuals over a number of years. Dr. Thomas was selected by his peers. He will receive the award during the academy fall meeting in Washington, D.C. this month.

Martin Wax, MD, Professor of Ophthalmology and Visual Sciences at Washington University School of Medicine received a one-year grant from the Glaucoma Research Foundation for a research project titled "Autoantibodies and Normal Pressure Glaucoma."

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In Memoriam

Alan H. Edelman, MD, 60, Creve Coeur, Missouri, died July 20, 1996. Dr. Edelman received his medical degree at the University of Missouri-Columbia in 1961. From 1965 to 1967, he served as a radiologist in the Air Force. Dr. Edelman was in private practice as a radiologist in St. Louis for more than 30 years. He was on staff for 25 years at Missouri Baptist Hospital. He was also on staff at Incarnate Word and Vencor hospitals in St. Louis and a consultant at Missouri Baptist Hospital in Sullivan, Missouri. He retired in 1994. He was a participant in and advocate for the Wellness Community. Dr. Edelman was a member of the American College of Radiology and the American Institute of Ultrasonics in Medicine.

Richard J. Ferry, MD, 60, Clayton, Missouri, died July 16, 1996. Dr. Ferry received his medical degree at St. Louis University in 1962. He completed neurology training at the University of Michigan in Ann Arbor. Dr. Ferry was in private practice in St. Louis for 30 years. He was an assistant clinical professor neurology at Washington University School of Medicine and director of the Electro Encephalogram Laboratory at Deaconess Hospital. Dr. Ferry was also a former clinical instructor and assistant clinical professor at St. Louis University School of Medicine. He was on staff at Barnes-Jewish, Deaconess and Incarnate Word hospitals and St. Mary's Health Center, where he was past president of the medical and dental staff. He was a member of the American Academy of Neurology.

Louis H. Forman, MD, 84, Prairie Village, Kansas, died August 2, 1996. Dr. Forman received his medical degree at the University of Kansas in 1939. He later served as a clinical professor of psychiatry at the University of Missouri and the University of Kansas medical schools. During World War II, he was a Captain in the U.S. Army Medical Corps, serving Africa and Europe. After the war, he completed his residency at Michael Reese Hospital in Chicago and the Chicago Institute of Psychoanalysis. Dr. Forman started the practice in Kansas City in 1950. He was chair of the department of psychiatry at Menorah Hospital, and was on staff at St. Luke's Hospital and Truman Medical Center. In 1980 his patients, friends and medical associates established a lectureship in his honor administered by the St. Luke's Foundation for Medical Education and Research. He was co-author of *Hello Sigmund, This is Eric*, published in 1978. He formerly was psychiatric consultant to Family and Children's Services of Kansas City, Jewish Family Services, Family Service of St. Joseph and Travelers' Aid of Kansas City. He served on the board of consulting physicians of the Richard and Annette Block Cancer Foundation, Panel of American Women and Project Hope. In the 1960s and 1970s, Dr. Forman lectured for husbands and wives at national meetings of the Young Presidents Organization; led discussions on client relationships for groups from the Kansas City Chapter of the American Bar Association; and taught at national meetings of Trial Lawyers of America and the National College of State Judiciaries. He lectured to Kansas City school teachers, the Junior League and social service agencies. He conducted seminars on psychosomatic medicine for internists and family physicians as a member of the Psychiatric Receiving Center in the 1960s. In 1977, Dr. Forman retired from teaching at the medical schools, but continued seeing patients, both in individual counseling and group therapy. He was one of the earliest practitioners of group therapy in Kansas City. Dr. Forman was a Life Fellow of the American Psychiatric Association. He was a member of the American Medical Association, American Group Psychotherapy Association, Academy of Psychosomatic Medicine and Central Neuropsychiatric Association. He had been a diplomate of the American Board of Neurology and Psychiatry since 1950. He was a Teaching Member of the International Transactional Analysis Association and received its innovative Teaching Award in 1981.

Sigmund Gundle, MD, 81, Prairie Village, Kansas, died August 4, 1996. Dr. Gundle came to the United States in 1939 and lived in the Kansas City area since 1954. He began his medical studies at the University of Vienna and received his medical degree at Washington University in 1943. He served in the U.S. Army Medical Corps from 1944 to 1948, achieving the rank of Major. He completed his psychiatric training at the Menninger Clinic and his psychoanalytic training at the Topeka Institute for Psychoanalysis, where he was a training and supervisory analyst until 1989. Dr. Gundle was one of the first psychiatrists in the U.S. to work full-time with college students and was a national advocate for fully-staffed student mental health services. From 1951 to 1954, he was Kansas University's student health psychiatrist and continued as a consultant

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there for another 20 years. He also served, for 25 years, as a psychiatric consultant to the student health service at the University of Missouri-Kansas City. Dr. Gundle was also a clinical professor of psychiatry at KU Medical School and School of Social Work and UMKC. From 1954 until 1992, he maintained a private practice of psychiatry and psychoanalysis in Kansas City. He was a life member of the American Psychiatric Association and the American Psychoanalytic Association. He was also a founding member of Psychoanalytic Study Group of Kansas City and received the Pioneer Award from the Bert Nash Community Mental Health Center of Lawrence, Kansas.

Antonio Q. Manansala, MD, St. Louis, Missouri, died July 17, 1996. Dr. Manansala received his medical degree at Manila Central University, Philippines in 1956. He came to the U.S. in 1955 and completed his internship and general residency at St. Francis Hospital, Witchita, Kansas. He completed a radiology residency at Colorado State Hospital and then returned to Manila. He returned to St. Louis after obtaining his Missouri license and entered private practice in Arnold, Missouri. From 1967 to 1979, Dr. Manansala served active duty in the U.S. Pacific Air Force, 655th Tactical Hospital Squadron as a Lt. Colonel, stationed at Yakota Air Force Base, Tokyo, Japan. He resumed his practice in Arnold from 1982 until his retirement in 1990. He practiced for 30 years in Arnold. He was on staff at St. Anthony's Hospital, St. Joseph Hospital and Faith Hospital West. Dr. Manansala served as past president of the Philippine Medical Society and past officer of the St. Louis Chapter of the Academy of Family Physicians. He was a member of the St. Louis Metropolitan Medical Society, American Medical Association, American Society of Abdominal Surgeons and the American College of Emergency Physicians.

John N. Martin, MD, 78, St. Joseph, Missouri, died July 26, 1996. Dr. Martin received his medical degree at Creighton University in 1943. During World War II he served in the Army Medical Corps. He completed his internship at St. Margaret's Hospital in Kansas City, Kansas, and his residency in urology at Methodist Hospital at Indianapolis. Dr. Martin went into practice with Dr. Robert Bristow of St. Joseph in 1956 and retired in 1986. He was a past president of the Missouri State Medical Association. He was a member of the Buchanan County Medical Society, American Medical Association, the South Central Section of the American Urological Association. Dr. Martin served on the Missouri Board of Registration for the Healing Arts.

Arlen E. Morrison, MD, 64, Creve Coeur, Missouri, died August 5, 1996. Dr. Morrison received his medical degree at Washington University in 1958. He was in private practice as a cardiologist for 30 years in St. Louis. Dr. Morrison was formerly on the faculty of Washington University School of Medicine and a past president of the Physicians Staff Association at St. Luke's Hospital. He retired in 1993. Dr. Morrison was a member of the American Society of Internal Medicine and the American College of Physicians.

James H. O'Neil, MD, 91, Prairie Village, Kansas, died June 22, 1996. Dr. O'Neil received his medical degree at Creighton University in 1930. He completed post-graduate work in surgery at the University of Pennsylvania. Dr. O'Neil was a practicing physician in Kansas City from 1937 to 1975 at St. Mary's Hospital, where he was chief of staff. He also served on the staffs of the General Hospital and Baptist Memorial Hospital. Dr. O'Neil was a Fellow of the American College of Surgeons and President of the Southwest Clinical Society. He was also a member of the International College of Surgeons and the Southwestern Surgical Congress.

Reese Potter, MD, 88, Webster Groves, Missouri, died July 31, 1996. Dr. Potter received his medical degree at Washington University in 1935. During World War II he served in the Army Medical Corps. Dr. Potter was a psychiatrist in private practice in St. Louis for nearly 40 years before he retired in 1992. He was formerly on staff at Barnes Hospital, the Labor Health Institute and the old St. Louis Sanitarium and the old Veterans Administration Mental Hygiene Clinic, where he served as chief of staff for several years. He was also a former faculty member at Washington University School of Medicine. He was a member of the American Psychiatric Association.

Joseph F. Trigg, MD, 91, Key Largo, Florida, died July 10, 1996. Dr. Trigg received his medical degree at the Royal College of Physicians, Edinburgh, Scotland in 1934. He served as a Navy medical officer in the South Pacific during World War II. Dr. Trigg on staff for 36 years at Missouri Baptist Hospital. He was a member of the American Academy of Family Physicians.

Studying Abroad in South Africa

Shandra Sheppard, 4th-year Medical Student
Washington University School of Medicine

How does a hospital run without adequate water to develop x-ray films? What are the signs and symptoms of Malaria? What is the most common cause of infant mortality worldwide? I learned the answers to all these questions during my six-week clerkship in rural Africa.

A well-rounded education is the mark of a true scholar is a belief I acquired during my education at a liberal arts college. In that spirit, I flew off to try and understand some of the important issues in the changing South African health care system. Studying abroad is one of the quickest, most memorable, and enjoyable ways of broadening my education. I learned lessons which are not possible to learn at home.

The hospital where I worked, Tinswalo Hospital, has approximately 92 beds, and a faculty (doctors, nurses, pharmacists, translators, and administrators) of less than 200. On the other hand, the population the hospital serves is large – approaching 200,000.

The recently-elected Nelson Mandela has been increasing governmental funds for this and other public hospitals, but diagnostic and treatment supplies are scarce. Deciding how to distribute and efficiently use scarce resources among a large population is a common, complicated topic in African discussions. In South Africa, a medical student's curricula includes rotations in health care administration as well as those in scientific study.

I feel fortunate to be formally and practically introduced to some of the politics that influence health treatments and distribution. I anticipate this knowledge will influence my thinking later in my medical career. As technology becomes more expensive and the struggle to balance the budget continues, resource distribution and improved-efficiency discussions are similarly necessary in the United States. Although American physicians tend to be interested in the science and not the administration of health care, the two undeniably go hand in hand.

In addition to the influence of politics in health care, I was exposed to the importance of culture in health care as well. Treatments and etiologies of STDs, HIV/AIDS, and contraception contain cultural components. For example, I learned that Depo-Provera shots are the most effective option for South African women who were dealing with family planning. An interest in contraception has arisen from women being unable to nourish or supervise too many children. Oral pills were first available, but led to wife-beating by angry husbands if the pills were discovered. Because of the strongly patriarchal and agricultural nature of the indigenous society, the culture-sensitive prevention using intramuscular injections is the better option.

Cultural ideas influence HIV/AIDS patterns through the practice of "inheritance." In this situation, a brother or other male relative of a recently deceased married man "inherits" his widowed wife and proceeds to engage in intercourse with her (even if the cause of her husband's mortality was AIDS!)

Other types of STDs are also influenced by culture. It is a common belief held by most rural South African women, that it is not normal if one does not itch or

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burn during micturition. Also, most believe to some extent that the "cleansing" or eradication of a STD in a male individual can be accomplished by his practice of intercourse with a virgin or young girl. It is difficult for a woman to refuse any man the privilege of intercourse, regardless of his relationship to her, his disease status, or her desire. These conditions, obviously, make STD spread an immense problem in Africa. I learned that to effectively treat or prevent many diseases, cultural contributions must also be addressed.

I also had the opportunity to meet patients with diseases I've only read about during schooling. I will never forget my patients with severe tetanus or "Chicken Gunya." And, I will always remember the ubiquitous malaria and tuberculosis bulletins throughout our hospital.

The new knowledge I acquired when studying abroad, was not strictly infectious diseases. Kwashiorkor and dehydration were far too common in our outpatient clinics. I doubt I will ever forget to recognize, treat, and consider the possible political and cultural etiologies of these conditions in the future.

The world is becoming a smaller place. People are increasing their communication across cultures and discovering the similarity of their problems. These experiences encourage broad-mindedness. In addition to the traditional education, physicians studying abroad may become interested in health care politics, the cultural aspects of disease developments, and may obtain a general global perspective. He or she will also realize that doctors bring their personal water from home to rural hospitals for developing x-rays in times of drought, that the most common symptoms of malaria are fever, nausea/vomiting, and diarrhea, and that diarrhea and dehydration are the most common cause of infant mortality in the world – at least they will if they study at Tinswalo Community Hospital in South Africa. MoMed

Attention Medical Students:

This is the monthly student section of *Missouri Medicine.* It is a great forum for us to voice our opinions, share our experiences, and highlight issues important to us. We need to consistently submit articles to the journal to maintain the regularity of this section. I am asking all of you to please take advantage of this opportunity and send in articles and updates about your chapter's activities. If you have any questions, feel free to contact any of your MSMA-MSS Officers. Thank you.

– Neal Sikka, MSMA-MSS Vice Chair

Exclusion of Physicians

Thomas D. Watkins

Traditionally, physicians faced only exclusion from hospital medical staffs under circumstances in which a hospital demonstrated that the physician's medical care was substandard. In today's environment, however, there is a new specter on the physicians' horizon, that being the exclusion of the physicians from managed care plans and the prospect of economic credentialing at hospitals. This article will describe the various types of exclusion that occur and the current state of the law.

Some aspects of physician exclusion are relatively new and are continuing to develop in legal theory. Further, the exclusion of a particular physician in a specific instance may give rise to a cause of action because of the method used to exclude the physician, or simply because of the particular facts of that case. Accordingly, the reader should make no assumption about their specific situation from the information in this article, but should rather, seek the advice of an attorney.

A. **Exclusion of Physicians Through Peer Review.** It is well accepted that hospitals have an obligation to ensure that their patients have the services of properly licensed and qualified physicians while being treated at the hospital. Physicians today are accustomed to the peer review requirements imposed by law and the national accrediting organizations to ensure the proper licensing and competence of physicians on the medical staff.

Challenges to exclusion in these cases usually involve an attack on the process, claiming that the bylaws were not followed, or an attack on the individuals involved in the process, claiming an improper motive. In response to the high cost of defending these claims, and the deterrent they presented to effective peer review, the federal government and many states, including Missouri, passed laws to protect the peer review process. The Federal Act, the Health Care Quality Improvement Act (HCQIA), establishes protection from all monetary damages provided certain requirements are met. To qualify for immunity under HCQIA, a professional review action must be taken (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known.

The Courts recognize that there is a valid public policy in ensuring quality and have been reluctant to substitute their judgement for that of a hospital board of trustees where the process outlined by HCQIA is substantially followed and the hospitals and medical staffs have followed the provisions of their own bylaws. One recent case of interest is *Brian v. James E. Holmes Regional Medical Center*. The Court of Appeals overturned a lower court decision awarding a physician $4.2 million and upheld the termination of staff privileges due to disruptive behavior. Significantly, the Court

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of Appeals held that even if the hospital had not complied with the procedures listed above, it still qualified for immunity because the procedures provided for examining Dr. Brian's conduct were "fair under the circumstances," and that the issue was for the judge to decide, not the jury. I believe that this decision is a strong statement of the extent to which the courts will go to uphold Congress' intent to provide immunity for those engaging in legitimate peer review activity.

B. Exclusion of Physicians Through Closed Staff Privileges. Another type of exclusion occurs when hospitals limit staff privileges to physicians who are employees or who contract with the hospital to provide services in a specialized area on an exclusive basis. Most hospitals utilize closed staff privileges in certain specialty fields, such as radiology, emergency services and pathology. When a hospital switches from an open staff policy to a closed staff policy in one or more departments, those physicians who previously had privileges in the specialty areas are adversely affected and may seek legal action claiming the decision breaches their contractual rights under the hospital's bylaws or violates antitrust laws by limiting competition.

The United States Supreme Court has recognized that a hospital has the right to exercise some control over the identity and number of physicians to whom it accords staff privileges. Hospital governing boards generally have the right to grant or deny privileges using criteria which they have formulated, subject only to the requirement that the standards be reasonably related to furthering the goal of providing quality patient care, and that the hospital has not exercised its powers in an unreasonably arbitrary and capricious manner. There have been a number of different legal theories used by physicians in these cases, but for the most part, courts have rejected them. If there is a reasonable business justification, and the process affords the physician a fair opportunity to present his or her case to the hospital board, the Courts are unlikely to second guess the board.

There have been instances in which physicians who are competitors of the excluded physician have participated in the process. In these situations, the competing physician and the hospital may have some exposure, so physicians should be careful with their role if the physician against whom action is being considered is a competitor.

C. Exclusion of Physicians From Managed Care Organizations. Another area of current interest is the exclusion of physicians from managed care organizations. This is somewhat new to many physicians and poses a real threat to their practice. There are growing numbers of managed care organizations, typically HMOs and PPOs which have a financial interest in limiting their panel of physicians to a small number that have favorable utilization practices and/or are willing to enter into desirable fee arrangements. Typically these fee arrangements are either capitated or discounted fee for service with substantial withholds.

In both cases, there is a significant incentive on the part of the organization to do business with those physicians who have lower cost utilization. In fact, it is not unusual for the employer paying the bill and not the HMO or PPO, to establish financial incentives to encourage the use of lower cost physicians. As a result, those physicians who are not willing to meet the financial objectives may be excluded from the network. Physicians may also be excluded even though they are willing meet the financial objectives, based upon a variety of criteria the plan wishes to adopt.

There is a recent case in Florida, *Levine v. Central Fla. Medical Affiliates, et al.*, in which a physician was denied membership in a closed panel PPO and filed an antitrust action against the PPO. The Court of Appeals, in a unanimous decision, found for the PPO on all points in a holding that, I believe, will be followed by a majority of the courts. Again, the courts seem to give great deference to legitimate business reasons for the exclusion of physicians from managed care plans as well as hospital staffs.

D. Economic Credentialing. There has been some discussion in the literature recently about economic credentialing. This typically occurs as a result of business and financial issues, not quality of care.

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MSMA President Convenes HMO Medical Directors

Patrick J. Mills, MBA, CPA – MSMA Director of Health Care Finance

MSMA President Daniel F. O'Sullivan, MD of St. Louis chaired two meetings with HMO Medical Directors from Kansas City and St. Louis HMOs on July 10, in Kansas City and July 17 in St. Louis. These sessions were intended to open lines of communication with physicians operating in the managed care environment.

All Missouri HMO Medical Directors were invited to attend. Those attending are listed to the right.

Dr. O'Sullivan expressed appreciation to the medical directors attending and suggested for discussion, "what we, as physicians, should be talking about among ourselves, and that is the quality of patient care." He posed the following logic problem, "the best care is the least expensive," he said. "When you try to reverse this and say 'the cheapest care is the best care' it will not work," he added. "As physicians we are all concerned about patient care, as representatives of MSMA we are concerned about developing a dialogue with managed care organizations because of how managed care policy impacts the delivery of care. A goal of this dialogue should be how to get information to physicians which will assist them in their medical decision making process," Dr. O'Sullivan said.

Utilization Data

Dr. O'Sullivan expressed concern that physicians are not always receiving feedback from HMOs. Physicians could be unaware of being outside the norms by which the HMO assesses physicians of a particular specialty. Since most of these problems develop out of insufficient communication, MSMA requested that Missouri HMOs share physician-specific utilization data with physicians on their panel. This would allow every physician to understand how they compare to their peers. With this information physicians would be aware that they might be a cost outlier before an HMO begins corrective action based on claims data.

Several HMOs indicated that they were already sending reports to their physicians, although most of those have been doing so for less than one year.

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HMO Medical Directors in Attendance

Alliance for Community Health	J.D. Malone, MD
BlueChoice	Margarethe Hagemann, MD
Blue Cross Blue Shield of K. C.	Robert Masterson, DO
CIGNA Healthcare of St. Louis	Emil F. Miskovsky, MD
Community Health Plan	John Listerman, MD
FirstGuard Health Plan	James True, MD
GenCare Health Systems	William Kincaid, MD
Group Health Plan	Robert Packman, MD
HealthNet	Ron Parton, MD
Humana	Robert Ross, MD
Kaiser Foundation Health Plan	Joseph Goldberg, MD
Mercy Health Plan	James Coates, MD
Missouri Advantage	Don Cole, MD
Prudential	Richard Fallon, MD
Truman Medical Center	Paul Williams, MD

MSMA Requests Proposals for CVO

At the 1996 MSMA Annual Meeting the House of Delegates adopted: Resolution #3 "Statewide Credential Verification Service."

RESOLVED, that the MSMA, in conjunction with component medical societies, offer a member benefit of a credential verification service that meets all of the standards established by the JCAHO and the NCQA.

To proceed with this resolution, MSMA needs to receive proposals for the operation of a CVO. MSMA has circulated a request for proposal (RFP). Any party willing to submit a proposal should contact MSMA in Jefferson City. MSMA will continue to work with component medical societies in the implementation of this resolution.

HMO Medical Directors Meeting, Cont. from page 579

Credentialing

MSMA and HMOs were again able to find common ground on the topic of credentialing. HMO Medical Directors expressed concern for the integrity of the data which is being gathered. It is their desire to have original source verification be performed. More importantly, the requirements of the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) and the NCQA (National Committee on Quality Assurance) must be met to ensure the HMO is eligible for accreditation.

Some HMO Medical Directors are anxious for the MSMA to initiate a credential verification organization (CVO) subject to JCAHO and NCQA review. Then they would be able to perform less original source verification, by accepting the CVO as their credentialing agent. Physicians would also benefit from a CVO by outsourcing credentials work which has increased the administrative burden placed on their offices.

Other items discussed included: one statewide standard credentialing application, use of the Internet's World Wide Web for posting HMO policies, use of electronic mail for eligibility, and MSMA creating an management service organization (MSO). MoMed

The Missouri State Medical Association would also like to express thanks to Ron Cosens of Metropolitan Medical Society of Greater Kansas City and Ron Garrett of St. Louis Metropolitan Medical Society for hosting these meetings.

Medical Legal Issue: Physician Exclusion

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For example, because physicians control 70% or more of a hospital's costs, hospitals have a business incentive to be concerned with a physician's practice pattern where the hospital is compensated on a DRG or other form of capitated payment.

A hospital may have a business incentive to limit competition for a physician who has been recruited by the hospital and is working under a practice support agreement. This is not likely to affect physicians already practicing in the community, as the hospital shouldn't give a practice support unless there is a community need, but it may affect new applicants.

Finally, in today's competitive environment, a hospital may have an incentive to limit its medical staff to those physicians who support the hospital. For example, if a physician refers his or her profitable procedures to a competing hospital or his or her own ambulatory surgery center, leaving only the unprofitable procedures for the hospital, the hospital may not want that physician on its staff.

These issues resemble the situations where exclusion is based on legitimate business considerations. While there have been very few economic credentialing cases, I believe the courts may analyze the cases in much the same way as in exclusive contract and managed care cases. If so, they may uphold the actions of hospitals or other facilities which base their decisions on sound business principles, so long as the decisions are not arbitrary or capricious, and follow the bylaws.

In summary, these are difficult times for physicians. Many physicians are not only medical practitioners, but also small business men and women who are facing massive changes in the way they do business. It is critical to understand the issues and pressures that they and hospitals face and be realistic about their environment. Hospitals and physicians must develop a positive proactive working relationship to deal with these complex issues. MoMed

The Author

Thomas D. Watkins practices law in St. Joseph, Missouri. His practice emphasis is corporate and health care law.

Traditional Medicare

Plan	Traditional Medicare
Monthly Premiums	Part B- $42.50
Hospital Inpatient	First 60 days: $736 copay Days 61-90: $184 per day Reserve days: $368 per day
Physicians and Specialists	$100 deductible 20% copay for all services
Skilled Nursing Facility	Three days prior hospital care required First 20 days of benefit period: no copay Days 21-100 of benefit period: $92 per day Over day 100 of benefit period: no coverage
Ambulance	20% copay of billed amount for hospital; 20% copay of allowed amont for independent
Emergency Care	20% copay after $100 Part B deductible
Preventive Care	Limited coverage
Outpatient Pharmacy	Not covered if drugs are self-administerable
Routine Dental	Not covered
Mental Health	**Inpatient:** Same as hospital coverage; 190 lifetime day limit **Outpatient:** 50% copay after $100 Part B deductible

This information about Missouri Medicare HMOs is supplied by the Health Care Financing Administration (HCFA) and is being printed for the benefit of members of the Missouri State Medical Association.

The following three pages have benefit information for Kansas City and St. Louis HMO Medicare plans.

Standard benefits are listed on this page for comparison.

MEDICARE MANAGED CARE PLANS

Medicare beneficiaries can enroll in managed care plans, also called Health Maintenance Organizations (HMOs). In general, HMOs cannot screen applicants to see if they are healthy, or delay coverage for pre-existing conditions. The only enrollment criteria for Medicare HMOs are the following:

1. You must be enrolled in Medicare Part B and continue to pay the Part B premium.
2. You must live in the plan's service area.
3. You cannot be receiving care from a Medicare-certified hospice.
4. You cannot have permanent kidney failure or have received a kidney transplant in the last 36 months.

If you develop permanent kidney failure after joining a plan, the HMO will provide, pay for, or arrange your care. Plans must also provide information about hospice services in your area if you choose to receive this kind of care after enrollment in the plan. As with traditional Medicare, all services provided by a managed care plan must be medically necessary.

The HMOs described in this directory are risk plans. This means that beneficiaries are "locked-in" to the HMO. All Medicare services, except for emergency or urgently-needed services in or out of the plan's service area, must be provided or arranged through the HMO. Unauthorized services do not have to be paid by the HMO and are not covered by Medicare.

This directory is not a definitive listing of Medicare benefits offered by managed care plans in the St. Louis and Kansas City areas. If you would like additional information about a particular plan, contact the appropriate number listed below:

Kansas City

Good Health HMO, Inc.	(816) 395-2525
Total Health Care, Inc.	(816) 395-2525
Humana	(816) 941-4670
Kaiser Permanante	(816) 469-5607
HealthNet	(816) 460-4688

St. Louis

Blue Choice Senior	1-800-366-2583
GenCare or Physicians' Heath Plan	(314) 878-6990 1-800-535-9291
Advantra	1-800-533-0362

Benefit Comparison - Kansas City (July 1996)

Plan	Good Health HMO, Inc.	Good Health HMO, Inc.	Good Health HMO, Inc.	Humana	Humana
Product Name	Blue Advantage 65 Value	Blue Advantage 65 Bonus	Blue Advantage 65 Premium	Gold Plus Value	Gold Plus Premium
Counties Served	MO- Jackson, Clay, Cass, and Platte; KS- Wyandotte, Johnson	MO- Jackson, Clay, Cass, and Platte; KS- Wyandotte, Johnson	MO- Jackson, Clay, Cass, and Platte; KS- Wyandotte, Johnson	MO- Jackson, Clay, Cass, and Platte; KS- Wyandotte, Johnson	MO- Jackson, Clay, Cass, and Platte; KS- Wyandotte, Johnson
Monthly Premiums	$0	$35	$50	$0	$75
Hospital Inpatient	No copay; unlimited days	No copay; unlimited days	No copay; unlimited days	No copay	No copay
Physicians and Specialists	$10 copay	$5 copay	$5 copay	$10 copay	$5 copay
Skilled Nursing Facility	No copay 150 days max.	No copay 150 days max.	No copay 150 days max.	No copay, 100 days per benefit period	No copay, 100 days per benefit period: 50 additional lifetime reserve days
Ambulance	No copay	No copay	No copay	$25 copay	$25 copay
Emergency Care	$25 copay	$25 copay	$50 copay	$50 at ER, waived if admitted to inpatient	$25 at ER, waived if admitted to inpatient
Preventive Care	Annual exam; routine hearing and eye exams; $500 lifetime hearing aid max.	Value plan, as well as 1 pair of standard lenses and frames every other year.	Same as Value Plan	No copay. Annual hearing test and eye exam for fitting of eyeglasses. $500 lifetime allowance for hearing aids. $20 copay for 1 pair of eyeglasses every 12 months.	Same as Value Plan
Outpatient Pharmacy	$10 generic $20 brand $500 annual limit	$8 generic $15 brand $750 annual limit	$5 generic $5 generic $750 annual limit	$10 per prescription $500 annual cap with $300 quarterly maximum	$7 per prescription $1000 annual cap
Routine Dental	No coverage	Oral exam and cleaning, 2 per year. Limited X-ray	No coverage	None	None
Mental Health	**Inpatient:** No copay; 190 lifetime days **Outpatient:** Subject to PCP referral and $10 copay(s)	Same as Value Plan with $5 copay(s)	Same as Value Plan	**Inpatient:** No copay; 190 lifetime days **Outpatient:** $10 copay	**Inpatient:** No copay; 190 lifetime days **Outpatient:** $5 copay

Information from HCFA provided for the members of the Missouri State Medical Association and their patients.

Benefit Comparison - Kansas City (July 1996), *Continued*

Plan	**Kaiser Permanente**	**Kaiser Permanente**	**HealthNet Senior Excel**	**HealthNet Senior Excel**	**Total Health Care, Inc**
Product Name	Senior Advantage Silver Plan	Senior Advantage Gold Plan	Plan A	Plan B	Total Health Care 65
Counties Served	Jackson, Clay, Platte and Cass (select zip codes) KS- Johnson, Wyandotte	Jackson, Clay, Platte and Cass (select zip codes) KS- Johnson, Wyandotte	Jackson, Clay, Platte KS- Johnson, Wyandotte	Jackson, Clay, Platte KS- Johnson, Wyandotte	Jackson, Clay, Cass, Platte; KS- Wyandotte, Johnson
Monthly Premiums	$0	$30	$19	$0	$106
Hospital Inpatient	No copay, unlimited days	No copay, unlimited days	No copay, unlimited days	No copay, unlimited days	$50 copay per admission; unlimited days
Physicians and Specialists	$10 copay	$5 copay	$5 copay	$10 copay	$5 copay
Skilled Nursing Facility	No copay; 100 days max. per benefit period	No copay; 100 days max. per benefit period	No copay; 100 days max. per benefit period	No copay; 100 days max per benefit period	No copay
Ambulance	No copay	No copay	$25 copay	$25 copay	No copay
Emergency Care	$25 copay; waived if admitted	$25 copay; waived if admitted	$50 copay; waived if admitted	$50 copay; waived if admitted	No copay
Preventive Care	$10 copay for hearing and eye exams, $20 eyeglass credit; $10 copay for annual physical	$5 copay for hearing and eye exams, $50 eyeglass credit; no copay for annual physical	$5 copay for annual exams, routine hearing and eye exams; 1 pair eyeglassses every 2 calendar years. Up to $400 hearing hardware benefit every 3 years	$10 copay for annual exams, routine hearing and eyeexams. Up to $400 hearing hardware benefit every 3 years.	$5 copay Annual physical and limited immunizations, routine hearing and eye exams
Outpatient Pharmacy	$10 copay for 60 day supply $1,000 annual benefit	$5 copay for 60 day supply unlimited annual benefit	$5 generic/$10 brand copay $750 annual limit	$8 generic/$12 brand copay $500 annual limit	50% of cost $250 annual limit
Routine Dental	Not covered	Not covered	Not covered	Not covered	Not covered
Mental Health	**Inpatient:** No copay, 190 lifetime days; additional 30 days per year **Outpatient:** $10 copay - visit 1- 20; $25 copay - Additional visits	**Inpatient:** No copay, 190 lifetime days; additional 30 days per year **Outpatient:** $5 copay - visit 1- 20; $25 copay - Additional visits	**Inpatient:** No copay, 190 lifetime days **Outpatient:** $5 copay	**Inpatient:** No copay, 190 lifetime days **Outpatient:** $10 copay	**Inpatient:** No copay; 190 lifetime days **Outpatient:** Subject to PCP referral and copay(s)

Information from HCFA provided for the members of the Missouri State Medical Association and their patients.

Benefit Comparison - St. Louis (May 1996)

Plan	**Alliance Blue Cross/ Blue Shield**	**GenCare**	**Physicians Health Plan**	**Physicians Health Plan**	**Group Health Plan, Inc.**
Product Name	Blue ChoiceSenior	CARUS	CARUS	CARUS Plus	Advantra
Counties Served	MO- St. Charles, St. Louis City and County	MO- St. Charles, St. Louis St. Louis City and County	MO-Franklin (select zip codes) Jefferson, St. Charles, St. Louis City and County	MO-Franklin (select zip codes) Jefferson, St. Charles, St. Louis City and County	MO- Franklin, Jefferson, St.Charles, Warren counties St. Louis City; IL- Jersey, Madison, Monroe, St. Clair, Macoupin (select zip codes)
Monthly Premiums	$0	$0	$0	$49	$0
Hospital Inpatient	No copay; unlimited days	No copay; unlimited days	No copay; unlimited days	No copay; unlimited days	No copay
Physicians and Specialists	$10 copay PCP $15 copay Spec.	$10 copay	$10 copay	$10 copay	No copay
Skilled Nursing Facility	No copay, 100 days per benefit period	No copay, 100 days per benefit period	No copay, 100 days per benefit period	No copay, 100 days per benefit period	No copay, 100 days per benefit period
Ambulance	$50 copay	$50 copay	$50 copay	$50 copay	No copay
Emergency Care	$15 copay PCP $50 copay ER, waived if admitted to hospital	$40 copay at ER, waived if admitted inpatient within 24 hrs	$40 copay at ER, waived if admitted inpatient within 24 hrs	$40 copay at ER, waived if admitted inpatient within 24 hrs	No copay
Preventive Care	$10 copay PCP, $15 copay Spec.; Periodic health exam; discounted eyeglasses; No copy for hearing test; Discounted prices on hearing aid	$10 copay; routine preventive services; one eye exam per year; hearing exam when ordered by PCP	$10 copay; routine preventive services; one eye exam per year; hearing exam when ordered by PCP	$10 copay; routine preventive services; one eye exam per year; hearing exam when ordered by PCP	Periodic health exam as deemed medically necessary; one annual eye and hearing exam; $10 per pair/year for eyeglasses with select frames
Outpatient Pharmacy	$10 copay per prescription	$5 copay for a 30-day supply; $500 annual cap	$5 copay for a 34-day supply; $15 copay for 90-day supply by mail order order; $500 annual cap	$5 copay for a 34-day supply; $15 copay for 90-day supply by mail order $1000 annual cap	$3 Health Center $5 non-Health Center $500 annual cap
Routine Dental	Discounted prices	One exam per year No copay	One exam per year No copay	One exam per year No copay	One exam every 6 months
Mental Health	**Inpatient:** No copay first 60 days. $25 per day after day 60; 190 day lifetime limit **Outpatient:** $20 copay per visit	**Inpatient:** No copay first 60 days. $25 per day after day 60; 90 day max per benefit period; 190 lifetime reserve days **Outpatient:** $20 individual; $10 group	**Inpatient:** No copay first 60 days. $25 per day after day 60; 90 day max per benefit period; 190 day lifetime reserve days **Outpatient:** $20 individual; $10 group	**Inpatient:** No copay first 60 days. $25 per day after day 60; 90 day max per benefit period; 190 day lifetime reserve days **Outpatient:** $20 copay individual; $10 copay group	**Inpatient:** No copay first 60 days.$25 per day after day 60; 90 days per benefit period; 190 days lifetime lifetime max. **Outpatient:** $20 copay individual; $10 copay group

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The Explosive Growth of Management Services Organizations (MSOs): What Does It Mean? What Does It Portend for the Future?

Richard L. Reece, MD, Chair
National Association of Integrated Health Organizations, Fredricksburg, Virginia

In the last three years, Management Services Organizations (MSOs) have become all the rage among physicians, among hospitals, and among Wall Street investors. By my reckoning, about 1,200 MSOs have sprung up across the United States. Compare this to about 2,500 existing IPAs and 3,000 PHOs. It is difficult to estimate the exact number of MSOs because they are not publicly registered, may operate under different titles, and are started by varying types of organizations – physicians, private investors, billing companies, hospitals, and managed care organizations.

To add to the confusion, MSOs may perform different functions – some may simply be service bureaus, other may offer comprehensive practice management services for medical groups, and still others may acquire the hard assets of individual practices and consolidate these practices into a regional or national firm. What MSOs share in common is that they provide services for managing managed care contracts and for managing practices. Ideally, these services will increase the valuation of physician practices by gaining more managed care contracts, by making the practices more efficient, and by helping physicians become more productive.

We can say with exactitude that 31 Practice Management Companies have gone public through the Initial Public Offering process, and that these companies are prominent on the radar screen of Wall Street because of their stock market performances since their offering (see Table 1 for data through August 26, 1996 on eight of these companies).

Why The Explosive Growth of MSOs?

Reasonable people may differ as to why MSOs are growing so fast. Here are my explanations.

1) The macro-response to managed care and the thirst for capital. Anybody who has been paying any attention at all to the managed care market knows you have to be big and be better to compete. You have to have economies of scale and sophistication. You have to have such critical tools as information systems, management expertise, capitation, networks of physicians for wide geographic coverage, and the ability to coordinate coverage across the spectrum of care. And, most of all, you have to aggregate and integrate physicians into organizations so you can have access to capital. And to qualify for capital, physicians will have to operate within the context of disciplined business organizations.

There is a tremendous thirst for external capital among physician organizations. If this capital comes from hospital systems, many physicians feel they will become servants of those systems. Physician groups need capital to merge with other practices, to form new organizations, to buy out retiring members, to build new clinics, to hire or acquire new physicians, and to develop sophisticated new information systems.

PPM Valuation Trends

Initial Public Offering Aftermarket Performance of PPMs

Company Name - TICK	IPO Date	IPO Price	08/26/96 Price	% change (from IPO)
Phycor, Inc. - PHYC (1)	01/22/92	$7.11	$33.00	364.1
FPA Medical Mgmt. - FPAM (1)	10/21/94	5.00	23.75	375.0
MedPartners/Mullikin - MDM	02/22/95	13.00	20.00	53.8
AHI Healthcare Systems - AHIS	09/29/95	14.00	5.50	(60.7)
Average				**183.1**
EquipMed, Inc. - EQMD (1)	11/15/93	7.00	7.13	1.9
Physician Reliance Network - PHYN(1)	11/23/94	9.75	12.00	23.1
MedCath, Inc. - MCTH	12/07/94	14.00	15.38	9.9
Orthodonic Centers of Amer - OCAI (1)	12/20/94	5.50	35.25	540.9
OccuSystems, Inc. OSYS	05/09/95	14.00	28.25	101.8
American Oncology - AORI (1)	06/13/95	10.50	9.00	(14.3)
Physicians Resource Group - PRG	06/23/95	13.00	23.63	81.8
Average				**106.4**
Coastal Physicians Group - DR	6/21/91	11.50	5.13	(55.4)
InPhyNet Medical Mgmt. - IMMI	08/19/94	12.00	14.00	16.7
EmCare Holdings - EMCR	12/08/94	11.00	23.75	115.9
STAT Healthcare - STHC(1)	04/21/95	3.75	6.25	66.7
Pediatrix Medical Group - PEDX	09/20/95	20.00	47.25	136.3
Sheridan Healthcare - SHCR	10/31/95	13.00	8.50	(34.6)
PhyMatrix Corporation - PHMX	01/24/96	15.00	24.63	64.2
Average				**44.2**
Dow Jones Industrial Average	06/21/91	2965.56	5693.89	92.0
S&P 500	06/21/91	377.75	663.88	75.7

Three basic sources of investment capital now exist for physicians: hospital systems, venture capitalists, and publicly traded physician management companies, such as MedPartners, PhyCor, or FPA Medical Management. Hospitals are major players and want to wrap organized integrated delivery systems around themselves. Venture capitalists want in the game so they reap a 30 to 50% return on their investments in a promising new field – the consolidation of physician services. Practice management companies are anxious to provide capital so they can meet their Wall Street growth targets and increase their stock market value and satisfy their investors. The choice of capital for most doctors is between a homegrown integrated system dominated by not-for-profit hospitals, and an out-of-town company with no commitment to the community but with a higher potential return. It is not an easy choice.

Physicians are going to need capital if they're going to play with such big dogs as HMOs, managed care organizations, insurance companies, and hospitals. If they're going to play on the same field, physicians will have to be big dogs themselves. Hospitals have consolidated, managed care companies have consolidated, the Blues have consolidated, pharmaceutical companies have consolidated. The time has come for physicians to consolidate. We can no longer have 600,000 physicians practicing in 400,000 locations and operating as a cottage industry. To survive and take back medical care, physicians are going to have

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to join together in equity alliances - which are most likely to be a combination of a core group practice, a linking MSO, and an affiliated IPA - and to have information systems to manage their business and to give them constant feedback to monitor their performances and to improve their quality.

2) The recognition that physicians are the core of the delivery system. This recognition may seem so obvious as to be trite. But it is not trite. It is why Wall Street and large health care organizations have targeted physician acquisitions and changes in physician behavior as the key to future success. It is why hospitals stepped up their acquisitions of physician practices by 60% in 1994 and 70% in 1995. It is why Physician Practice Management firms are scrambling to acquire as many practices as they can in the next three to five years. It is why multiple state medical associations, including Michigan, Illinois, Texas, Pennsylvania, Kansas, Connecticut, and Missouri, are exploring or implementing MSOs.

When you realize that physicians are the only ones licensed to practice medicine, that physicians are responsible through their pens for 80 to 85% of costs, and that physicians with equity in large medical groups and IPAs in the Western United States have shown the capacity to outperform HMOs in their ability to lower costs and to satisfy patients, you begin to get a sense of why physicians in properly structured organizations are feeling so empowered.

In California, physician organizations feel strongly that they have supplanted hospitals as the heart of the health system and that "virtual integration" with physicians as independent contractors has just as many advantages as vertical integration under a hospital umbrella:

> *"Organizing a delivery system around the hospital has a less compelling logic with each passing year. There exist few scope economies between hospitals and physician services that cannot be achieved through contract; little advantage over integrated systems over contractual partnerships in bearing capitation risk; little if any gain in shifting the transaction costs of negotiating, monitoring and enforcing agreements from the external market to the internal pseudomarket; and only modest sharing of core competencies between running a hospital and running a network of primary care clinics."*[1]

3) The recognition among physicians themselves that they need a solid, well-managed, and well-financed business organization to represent them on the market. Many physicians increasingly feel they just want to practice medicine but they also want to shape the change process by being engaged as equity partners and with corporate partners who represent their best interests. On the whole, physicians like MSOs because they perceive MSOs as shelters in the gathering managed care storm. To physicians, MSOs offer these benefits:

- MSOs offer an organizational vehicle to level the competitive playing field with hospitals and managed care organizations.
- MSOs offer an opportunity for physicians to organize into business-minded alliances capable of acquiring capital to add other practices, invest in managerial and management enterprise, and to install information systems.
- MSOs offer an opportunity for equity in a physician-centric and physician-cooperative enterprise which provides contract management and practice management services.
- MSOs offer physicians the chance to be part of an efficiently run business with economies of scale that can attract managed care contracts.
- MSOs offer physicians a group environment in which they can learn from each other and from constant feedback from information systems.
- MSOs offer physicians an attractive investment opportunity and an exit strategy for retirement once their careers are over.

What Are the Characteristics of Successful MSOs?

According to Thomas Gorey, President of Policy Planning Associates, a Crystal Lake, Illinois consulting firm that analyzed seven successful MSOs for the AMA and five other medical societies, successful MSOs share these 15 features:[2]

1. They blend contract management and practice management services.

2. They require substantial capital, at least $1 million and to $20 million to develop and implement.
3. They have a clear vision and a strong business plan.
4. They have a qualified, experienced, and strong administrative staff.
5. They balance physician, administrative, and other interests in governance.
6. They're aggressive and take risks.
7. They incorporate medical groups and IPAs in their structure.
8. They aggressively expand geographically and deliver medical care from a distance.
9. They develop strategic "win-win" relationships with hospitals and payers.
10. They stick to their core competencies and reject the option of forming HMOs.
11. They concentrate on quality management.
12. They focus on utilization management.
13. They accept greater and greater levels of risk.
14. They pay their doctors through a combination of salary and financial incentives.
15. They recognize the central importance of information systems, but realize no perfect system yet exists.

Concluding Remarks

The last three years have witnessed an explosive growth of MSOs. These organizations, which may be owned by physicians, hospitals, private investors, or publicly traded companies, or a combination, provide contract managed and practice management services to physicians and may employ physicians. MSOs are tangible and highly visible evidence of the consolidation of the physician services industry, and are attractive to many physicians because they empower physicians competitively and position them favorably in the rapidly evolving $1 trillion health care industry, which is increasingly dominated by managed care. MoMed

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2. Gorey T. *Case Study Analysis of Management Services Organizations (MSOs)*, Sponsored by the American Medical Association, American Academy of Otolaryngology-Head and Neck Surgery, Indiana State Medical Association, Massachusetts Medical Society, Medical Society of the District of Columbia, Michigan State Medical Society, for copies write or call, Thomas M. Gorey, JD, Policy Planning Associates, 355 Cumberland Lane, Crystal Lake, IL 60014, 815-459-4516, $25 - members of a sponsoring medical society, $95 - nonmembers.

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The Management Service Organization (MSO) A Vehicle For Physician Integration

Tom Bennett, M.Div., MBA, MSW, GCG and N. Rock Erekson, MBA, CMPE

"Coming together is a beginning; keeping together is progress; working together is success."

– ***Henry Ford***

The acronym **MSO** has become as common as HMO, IPA, PHO and the rest of the health care alphabet soup. However, MSO, Management Service Organization, has a variety of meanings and functions. The context in which it is used in this paper is: "a business entity that can provide a broad array of business related services to physicians, physician groups and physician directed networks **in order to improve the quality and efficiency of the delivery of health care and to act as the catalyst in the whole process of tighter integration of medical practice.**

The common context of MSO is as a hospital-based entity that provides a narrow range of services, such as billing/collections and human resource management to physicians/groups on a contractual basis. The use of MSO in this paper is much broader, as it touches on **each and every aspect of the economic exchange as it pertains to the practice of medicine,** be it solo practice, group practice or via a physician directed network. A management service organization, however, is not an entity unto itself, but should be regarded as a supportive entity whose very existence depends on enhancing the delivery of health care.

As the downward spiral of reimbursement continues, pressured by managed care, physicians are struggling to maintain and enhance income levels, while at the same time striving to provide improved quality service. Those physicians who do not change their operational and management approaches are experiencing the consequences: declining individual and practice income, the loss of patients to other physicians, and the continuous pressure to work longer hours.

The external pressure to reduce cost and maintain quality and service is moving the health care industry into a rapid mode of integration. Many medical groups and practices will be confronted with the difficult choices concerning how their operations will be integrated into the larger health care delivery system.

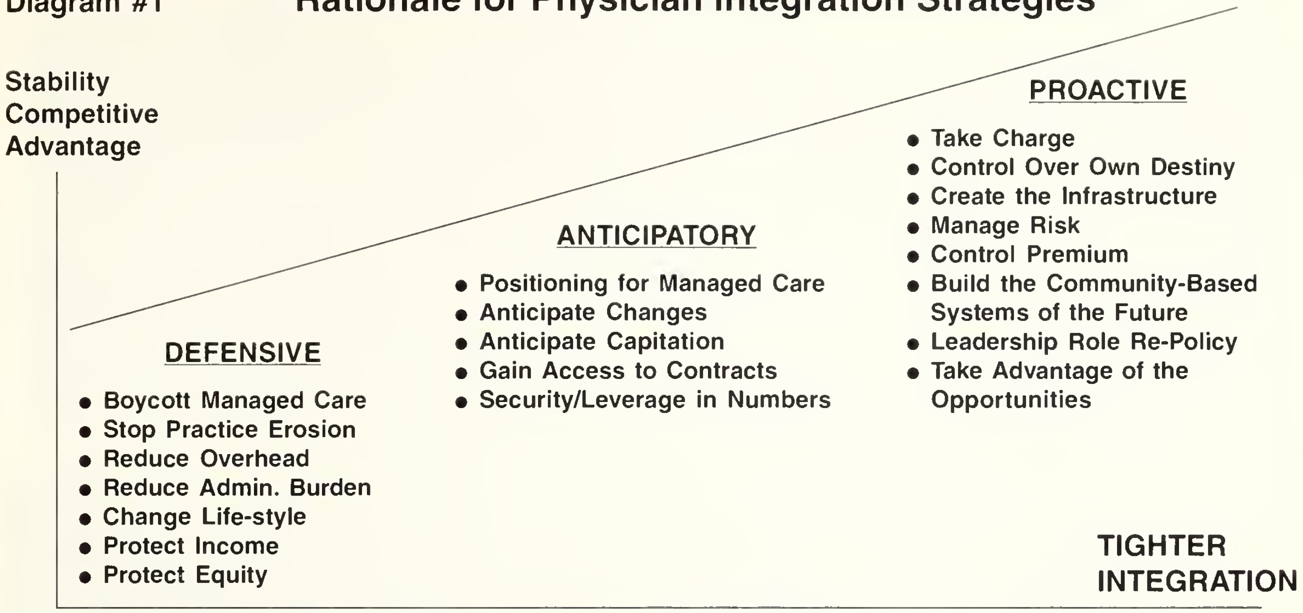
Employed Physicians

As the "cottage industry" period of medical practice is fast drawing to a close, and as this rapid trend towards physician integration continues, it is projected that the solo practitioner and small group practice will have a very difficult time surviving in this very competitive market place. It is estimated that within the next 5 years most physicians will become **employed physicians** in one of the following categories:

- ☐ Member of an independent specialty or multi-specialty group.
- ☐ Member of a hospital based group.
- ☐ Member of a MCO/Insurance based group.
- ☐ Member of a federal program.
- ☐ Member of a state program.
- ☐ Member of a university based practice plan.
- ☐ Member of private business group panel.
- ☐ Member of a PPM group.
- ☐ Member of an ancillary provider group.

Many physicians/groups are, therefore, seeking to achieve a more integrated approach to the delivery of health care and combine a full array of management and physician services into a well organized, seamless delivery system that will be able to demonstrate quality and outcomes, while at the same time incrementally assuming RISK for a defined group of people. (Diag. #1)

Diagram #1 **Rationale for Physician Integration Strategies**


Stability
Competitive
Advantage
DEFENSIVE
• Boycott Managed Care
• Stop Practice Erosion
• Reduce Overhead
• Reduce Admin. Burden
• Change Life-style
• Protect Income
• Protect Equity
ANTICIPATORY
• Positioning for Managed Care
• Anticipate Changes
• Anticipate Capitation
• Gain Access to Contracts
• Security/Leverage in Numbers
PROACTIVE
• Take Charge
• Control Over Own Destiny
• Create the Infrastructure
• Manage Risk
• Control Premium
• Build the Community-Based Systems of the Future
• Leadership Role Re-Policy
• Take Advantage of the Opportunities
TIGHTER
INTEGRATION

Source: Integrated Healthcare Report

Control

Many physician practices are not thriving under managed care because the historical tenets of the practice of medicine are no longer appropriate and effective in delivering health care today. The rugged individualism and autonomy that have been the cornerstones of medical practice preclude the organizational, management and decision making styles that are effective in the current health care environment.[1]

Physicians/groups are now being faced with a major dilemma: compromise on their autonomy in exchange for being part of a larger organization that has centralized decision-making. This particularly aspect of loss of autonomy is one of the most difficult decisions that physicians face as they contemplate the move into more integrated modes of practice, because their training has cultivated physicians to be independent thinkers and decision makers.

Physicians/groups who may be contemplating integrating their practices can effectively use the services of an MSO as the **interim stage** in the integration process. The level of integration in the management services relationship is not as comprehensive as other integration models, but it is a bold step forward, and it does appeal to physician autonomy by keeping the medical group/practice ownership, governance and employment relationships with its physicians intact. If the relationship among the physicians/groups within the MSO is successful, then this courtship will lead to the marriage of physicians and groups into full economic and clinical merger. On the other hand, if physicians are not able to work together via the MSO, any further integration should not be considered.

Physician Practice Management Company (PPM)

A clear distinction must be made between a Management Service Organization (MSO) and a Physician Practice Management Organization (PPMs) e.g., MedPartners, PhyCor, PhyMatrix, and Coastal. These PPMs blend the control of clinical services with the standardization of operations. PPMs offer physicians/groups a lucrative initial package of cash and stock in exchange for sale of assets and or the sale of the practice/group or a portion thereof. In evaluating these types of arrangements the physician/group should determine the true added value to their practice and the projected value of the stock over time. The aim of PPMs is to **consolidate, integrate and automate** physicians' practices through the development of clinical, operational and informational infrastructures in order to align with managed care payors.

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Diagram # 2

MSO MENU OF SERVICES

GROUP PURCHASING

- Office supplies
- Office equipment
- Medical supplies
- Office furniture
- Medical equipment
- Computer equipment
- Insurance:
  - Professional liability
  - Health
  - Auto
  - Auto lease
  - D & O / O & E
  - Dental
  - Casulty
  - Auto sale
  - Disability
  - Property
  - Auto rental
  - Travel

REIMBURSEMENT

- Coding/billing/AR management
- Reimbursement enhancement
- Reimbursement Quality Assurance
- Seminars and training programs in reimbursment
- Electronic interchange and payment transmission
- Fee schedules
- Reimbursement audit

MANAGEMENT INFORMATION SYSTEMS

- LAN and WAN design, installation and maintenance
- Data Management
  - Clinical
  - Financial/accounting
  - Utilization management
  - Operations
- Internet access and training
- Systems analysis

HUMAN RESOURCE MANAGEMENT

- Office staffing and recruitment
- Office training and continuing education
- Professional and technical recruitment and staffing
- Personnel management and regulatory compliance:
  - Policies and procedures
  - Task manuals
  - Job descriptions
- Payroll administration
- Benefits adminstration

PROFESSIONAL SERVICES

- Practice management consulting
- Cost accounting
- Legal
- Insurance (health plans/HMOs)
- Regulatory compliance
- Business Planning
- Group integration/mergers and acquisitions
- Claims management/TPA
- Credentialling
- Accounting (tax)
- Financial management/ budgeting/monthly reports
- Marketing
- Strategic Planning
- Network development and operations
- Grant writing/funding
- Clinical research

MAJOR PROJECTS

- Facilities design/planning and financing:
  - Surgicenters
  - Labs
  - Alternate Delivery Sites (ADS)
  - Imaging centers
  - Comprehensive testing and treatment centers
- Design and implementation of health plans/HMOs
- Purchase of major equipment
- Captial sources

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Are the benefits worth the cost? Because many of these types of organizations (PPMs) are publically traded, there are significant requirements in disclosure and accounting which most physicians have not been exposed to in their practices. The term EBIDT, Earnings Before Interest Depreciation and Taxes, will at some point become a watch word. Physicians must question whether these PPMs over time (5 to 7 years) improve their contracting capabilities, i.e. get more dollars for the current services and expand the service offerings, while at the same time reduce the cost of operations so as to more than offset the PPM fees, return to investors and the cost of increased reporting requirements.

PPMs have become the darling of Wall Street, and each and every month Initial Public Offerings (IPOs) are being offered through the stock exchanges. The first major foray of a PPM has recently taken place in the St. Louis Metropolitan area through First Physician's acquisition of a large multi-specialty group.

Physician revenues have increased from $155 billion in 1992 to $200 billion in 1995, and PPMs are projected to penetrate the market from the current 4% ($8 billion) to a 25% penetration rate ($50 billion) by the end of the millennium due to the increased growth of managed care.[2]

In major contrast to PPMs, the core functions of an MSO are related only to business and operations, not to clinical services, i.e., the MSO should only **support** the delivery of health care services and should **not control** the delivery of health care **nor control** the practice. Listed below are the basic characteristics of an MSO and PPM which contrasts their differences.

Characteristics of MSO:

- Focus on business/operational functions to create efficiencies;
- Reduction of operational expenses;
- Clinical autonomy;
- Operational autonomy;

- Initial phase of integration;
- Pay for services rendered.

Characteristics of PPM:

- Sale of assets and or practice for cash and stock;
- Less clinical autonomy;
- Less control over operations;
- Operations are standardized;
- Full merger into larger integrated network of providers;
- Portion or all revenue goes to PPM.

Nota Bene: the goals of an MSO and PPM are however similar i.e. increased integration in order to make physicians/groups more competitive through:

- increased operating efficiency;
- integrated MIS systems;
- access to capital;
- managed care contracts;
- integrated network of primary and specialty physicians.

How is this transition to tighter integrated systems going to take place? What is the best vehicle to accomplish this transition? An MSO can be the ideal vehicle to achieve this because it offers incremental decision making and affords physicians/groups choice from the menu of services. (Diag. # 2).

The best managed and best operated MSOs are those that are by-products of already existing successful practice organizations. These are groups/organizations that have a proven track record. These are groups and networks that have invested in building the necessary administrative, organizational and informational infrastructures, and are now able to thrive in the current market place. An MSO can be a vehicle that can be a revenue center besides a pure cost center. In essence, physician groups/networks are applying modern business principles and standards to create state-of-the-art corporate structures supported by sophisticated information technology affording the group the information and intelligence to make well-informed clinical, business and operational decisions.

Creating a management relationship often appeals to physicians because it keeps the medical group intact and does not require the physicians to be employed by the MSO. It places the MSO in a management relationship rather than in an ownership relationship with the physician's practice. Nor does this relationship interfere with the clinical judgment/decisions of the physicians. This is done at the peer review level.[3]

An MSO can quickly and easily provide access to resources for managed care negotiations/contracting, and the leverage for group purchasing arrangements, which can realize significant savings for the group/network and thereby reduce overhead. Group purchasing can range from the purchase of professional liability insurance to the purchase of high tech equipment and facilities. Even if a group/Physician Directed Network may have difficulty signing contracts, i.e. attempting to enhance their revenue, they may, however, achieve significant savings on their operational expenses through the use of an MSO. Often, the operational savings of an MSO more than pays for the membership dues of the Network.

The creation of a group/Physician Directed Networks does not in and of itself guarantee success, nor does the ownership of managed care contracts necessarily grant success. There must be a dual strategy of integration/medical management of clinical services and the reduction of overhead expenses. This latter strategy may be achieved through the provision of basic practice management resources to physicians via an MSO. Once again the MSO can be the vehicle to coordinate existing resources within the local community and arrange for other needed services, and thereby implement sound business principles for medical practice. *Nota bene:* the MSO can be as simple or sophisticated as the needs of the community.

Besides the MSO supporting disparate practices, as they attempt to economize on their business/operational expenses, it is also a vehicle for specialty IPAs to consolidate services. One such initiative is being planned in Kansas City where 7 specialty IPAs are planning to share such services as billing/collections, credentialing, group contracting particularly professional liability insurance, managed care contracting, MIS services and dictation services.

Many large groups have to invest heavily in building their own infrastructures only to find that the financing of the infrastructure places a major financial burden on the group. There are now large groups in the St. Louis area that are actively discussing the need to share resources and thereby reduce overhead through the formation of a joint venture MSO. Services from the joint MSO include: human resource management, accounting, billing/reimbursement, MIS, technical support/staffing, managed care contracting. The St. Louis area is primed for the consolidation of large groups into a large multi-specialty group of close to 200 physicians. A PPM through an MSO may be the catalyst to actualize this potential merger.

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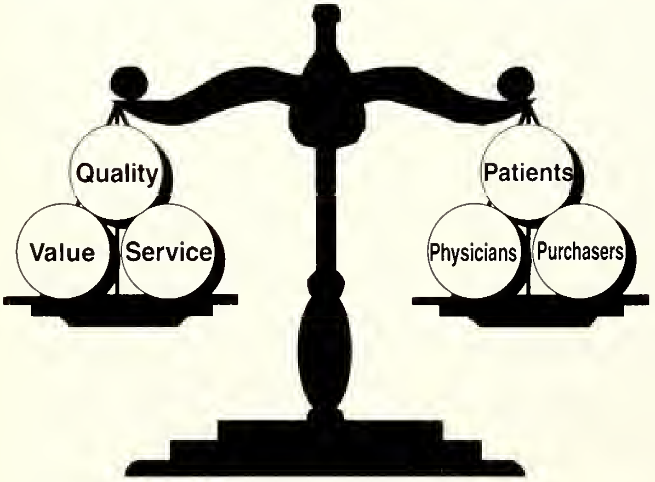
Capital Partner

The Achilles heel in many physician integration projects is the area of capital; the lack of which is the one critical factor that can doom a project to failure. What is the best source for capital for physician integration projects? Venture capitalists? Banks? PPMs? PPMs should also consider a more modified consolidation strategy through the financing of an MSO. The most obvious one is the physicians themselves, but other sources are ancillary providers and health care vendors.

As the hospital industry witnesses the continued reduction in hospital days due to shorter lengths of stay and lower admissions, hospitals are consequently downsizing inpatient services. In more advanced managed care markets inpatient commercial days per 1,000 enrollees is now under 200 as compared to the national average of 495, and for Medicare days per 1,000 enrollees is below 1,000 as compared to the national average of 2,835.[4]

In order to make up for this short fall in inpatient revenues, hospitals are aggressively attempting to control outpatient and related home care and ancillary services. The simplest way to achieve this goal is by purchasing physicians' practices and thereby controlling all associated revenues: inpatient, outpatient, home based, and ancillary care. If this trends continues the independent home care and ancillary providers will witness a reduction in their market share by lack of referrals from the independent physicians. It is, therefore, within the best interests of these home-based and ancillary providers to assist physicians in maintaining their independence by becoming better managed and organized through a Physicians Directed Network/MSO. It should be noted that the physician's pen (writing of orders) accounts for 80% the total expenditures in health care, and on a budget of close to a trillion dollars – that is a lot of clout.



Through economic partnerships with vendors and ancillary providers, an MSO/Network can also provide the capital for future operations and new affiliations. These groups have been required to use retain earnings to raise these funds, which consequently has reduced the income of the physician.

An MSO can be a very useful vehicle to create a partnership with a synergistic ancillary provider because it affords the ancillary provider a mechanism to assist physicians in becoming better organized, managed and operated, as well as meeting the legal requirements of fraud/abuse/kickback. All the resources that are provided to the group/network have to be accounted for and over time must be paid back to the MSO. What this vehicle gives to the physicians in the network/group is TIME to generate sufficient revenues to support its own operations and have the access to capital resources to continuously expand.

In order to effectively compete with hospitals, managed care organizations, insurance companies and other providers, physician groups/networks will have to engage the highest caliber of executive, technical and professional services. Physician groups/networks can access these resources in a very cost-effective manner via an MSO.

It should be noted that the author is not advocating the use of MSO/Network as the solution to the many ills of medical practice, but rather as the interim phase of the movement towards more clinically and economically integrated multi-specialty group practice, and eventually to the development of community-based alternate delivery systems (ADS). In the mean time, physicians have to create a balance of providing quality of care, superior service and added value to their primary constituents, i.e. patients and purchasers of health care. (Diag. #3) MoMed

My next article will deal with the structure of local MSOs and its relationship with the MSMS statewide MSO.

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The ABCs of Physician Practice Valuation

Timothy McIntire, MD, MBA

Deciding to sell a practice is one of the most important things a physician can do to impact his or her professional life. Should you sell or not? Should you sell to another physician-owned group, a hospital system or a group of practice management specialists? How do you go about finding the true value of your practice? How do you value the hard and soft assets? What are soft assets? Should you get cash or stock for your practice? How will your salary be affected by this transaction? All of these questions are important to address during the process.

As health care consolidates, the need to align physicians becomes important. Poor physician integration in health care entities interferes with the ability to compete for capitation contracts and achieve utilization efficiencies. It is important for physicians to have a leadership role in these times. Valuing their and other physician practices is one important aspect of this integration.

One of the most popular ways physicians integrate is through the acquisition of private physician practices. These acquisitions have become common place over the past few years. When assessing your practice's value, several characteristics can be of influence, including:

- ☐ how dynamic the local acquisition activity has been;
- ☐ what type of valuation methods are being used;
- ☐ what type of entities are purchasing the physician practices;
- ☐ how you value tangible assets, intangible assets, goodwill, etc.;
- ☐ what are the base and incentive compensation and benefits;
- ☐ how is the incentive plan calculated;
- ☐ what is the standard workload expected of the physician after the acquisition;
- ☐ what special benefits or retirement options are offered.

There are many factors which influence the value a physician can expect for their practice. The successful assessment of these factors will aid in a beneficial transaction. The following topics address some preliminary characteristics physicians should study and consider.

Physician Compensation

There are two common ways physicians are compensated in a practice agreement: a high purchase price with lower salary guarantees or a lower purchase price with higher salary guarantees. Regardless of the method, physicians should negotiate bonus payments hinged on productivity. Common productivity targets used include total hours treating patients, patients examined per hour and annual physician revenues.

Financing

It is usual in the acquisition of any professional service company to have a relationship between the valuation of the company and the financing method. A lower valuation is often seen if the entire purchase amount is paid in cash, as opposed to if the purchase price is paid over several years. While most physician practices are bought with cash (or cash equivalents such as stock in the acquiring company or medical group), the median premium paid, if financing is done over time, can approach 15-20%.

Assets

The valuation of a clinic involves the determination of the Fair Market Value (FMV) of both tangible and intangible assets. FMV refers to the price at which a buyer and seller agree, and at times may reflect other similar deals in the community. Tangible assets consists of real estate, accounts receivable and supplies. Intangible assets include patient files and goodwill. While intangible assets often account for the majority of the valuation, federal health care policy and laws often limit the value of intangible assets in a physician practice.

Valuation Methods

Three basic types of valuation are classically used in purchasing physician practices, they are: the Net Asset Value (NAV) technique, the Discounted Cash Flow (DCF) technique, and a mixture of the two. The most commonly used method is the NAV, it also produces the lowest values. While value is often very subjective, the NAV consists of the depreciated value of the physical property (building, machines, furniture, supplies, etc.) of the clinic and the accounts receivable. The future value or the business potential of the clinic is not assessed using the NAV technique. The DCF method takes into account the future potential earnings of the clinic, and often is a more favorable method for the selling physician. The combined methods of NAV and DCF are as creative as the buyers and sellers can imagine.

Managed Care Penetration

Primary care practices have high value in both low managed care markets and high managed care markets. In low managed care markets, primary care practices serve as a major source of referrals. In high managed care markets, primary care practices represent a force which attract HMOs. Primary care physicians also serve as gatekeepers through which utilization can be managed and costs controlled. Because primary care practices have value in both markets, increasing managed care penetration often serves as an inducement for physicians to sell, thus the prices are often bid up in rapidly evolving markets.

Specialist clinic valuation is very dependent on both the amount of managed care present and the supply of specialists in the area. The purchase of specialists is not very attractive in the early phases of managed care, mostly because everyone is concentrating on the primary care clinics. Later in the managed care evolution, as utilization decreases and the oversupply of specialists is accentuated, it becomes a buyer's market. Specialists then often attempt to become part of larger networks or groups as a defensive strategy to protect their patient base.

Malpractice Tail Coverage

When physicians merge with each other and trade stock in each company, both assets and liabilities are combined into the surviving corporation. However, a purchase, as opposed to a merger, involves the assets and not the liabilities of the practice. This means that any prior liability exposure is the responsibility of the previous owner (the purchased physician). Thus, some provision for malpractice tail coverage must be made. As an additional cost, tail coverage should affects the clinic's valuation, and one would expect this cost to decrease the value of the practice. Curiously, when hospitals purchase physician practices, the value paid per physician is often higher in the practices where the hospital assumed the malpractice liability than those practices where the liability was retained by the physicians. Possibly, as it relates to hospitals acquiring practices, malpractice costs are not a significant item in valuation. This point is very negotiable, be careful.

Non-Compete Clauses

Most physician practice acquisitions have some type of non-compete clause included in the transaction. It often consists of a 25 mile geographical boundary for a period of two years. Non-compete clauses have significant value to acquirers, often being worth 20-30% of the practice purchase price. Most of the value in a physician practice is tied to the patient relationships, thus physicians who refuse to sign a non-compete clause diminish their value considerably. This is one way to receive value for your intangible clinic assets, do not overlook it.

In conclusion, there are many ways to value a physician practice and there are many factors which may affect its value, and some familiarity with core principles will help in guiding the process. One must still identify the interests being valued, evaluate the office operations and physical assets, assess the market position and project the cash flows. A practice acquisition is such an important event for physicians, engaging an experienced professional is of paramount importance. MoMed

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The Cooperative Cardiovascular Project in Missouri

Gary J. Fortune, DO, MPH, Principal Clinical Coordinator, MPCRF,
and Simon Geletta, MS, Research Analyst, MPCRF

After spending the last three years as the Principal Clinical Coordinator for the Missouri Patient Care Review Foundation (MPCRF) and overseeing the clinical implementation of the Health Care Quality Improvement Program (HCQIP),[1] I have observed a dramatic and gratifying change in physician perception of quality improvement activities. Part of this change in perception is due to a decrease in individual physician medical record case review. Of greater significance has been the development of clinically-driven, local, cooperative projects which have generated increasing physician and hospital involvement in quality improvement activities.[2] HCQIP utilizes a collaborative quality improvement approach that does not imply blame, but rather focuses on improving the processes of care that cross departmental lines in order to achieve lasting improvement in patient outcome.

In expanding beyond local cooperative projects developed within Missouri, the Health Care Financing Administration (HCFA) requested that MPCRF participate in the national Cooperative Cardiovascular Project (CCP) in an effort to reduce Medicare beneficiary mortality due to acute myocardial infarction (AMI).[3] The statistics for AMI in Missouri are startling. Take for example just the scope of the problem. Missouri 1995 data indicate that over 10,000 Medicare beneficiaries suffered AMI with an in-hospital case fatality of 14% and a 30-day post-hospital mortality rate of 18%. This signifies a great need to examine current processes of care within the state to determine opportunities for improved care.

Over 200,000 AMI cases were abstracted nationally for CCP with 5,600 cases analyzed from Missouri acute care hospitals. Extensive research in AMI care with a large number of clinical trial results has lead to a high degree of clinical consensus and the development of quality indicators or measures for AMI treatment. MPCRF, in collaboration with the Missouri Chapter of the American College of Cardiology (ACC), reviewed the quality indicators (Table 1) and analytic results developed for CCP. MPCRF confidentially provided to acute care facilities their hospital-specific data, with comparative state-wide and national statistics in an effort to generate improvement efforts related to CCP.

The quality indicators developed and analyzed for CCP focused both on intra-hospital and discharge AMI treatment activities. Initial activity quality indicators include measuring the timing of reperfusion for both primary percutaneous coronary angioplasty (PTCA) and thrombolytics, and the use and timing of aspirin. Discharge quality indicators include assessing the prescribing of aspirin, beta blockers, angiotensin converting enzyme (ACE) inhibitors and calcium channel blockers at discharge.

In relation to intra-hospital activities, HCFA has recommended emphasis be placed on improving the timing of reperfusion and aspirin. State-wide data indicates that a median time elapsed from hospital arrival to administration of a thrombolytic is 53 minutes (Fig. 1), with 2.3 median hours elapsed to PTCA (Fig. 2). While most AMI patients are receiving aspirin during their hospital stay, fewer than 60% are given aspirin on the day of presentation (Fig. 3). These indicators identify areas for quality improvement related to the timing of initial AMI therapies.

Continued on page 603

Table 1. Quality Indicators

Confirmation of the AMI
Criteria: An elevated CPK-MB or an elevated LDH with LDH1 > LDH2 or two of the following: chest pain, a two-fold elevation of the CPK, or evidence of an AMI on the electrocardiogram.

Timing of primary PTCA
Eligible: All patients with confirmed AMI receiving a PTCA within 12 hours after arrival to the hospital and having adequate documentation at the time of arrival and the time of the PTCA.
Criterion: The time (in minutes) from arrival at the hospital until beginning of the PTCA (wire time).

Timing of thrombolytics
Eligible: All patients with confirmed AMI receiving thrombolytics and having adequate documentation of the time of arrival and the time of administration of the thrombolytic.
Criterion: The time (in minutes) from arrival at the hospital until beginning of administration of the thrombolytic.

Aspirin during the hospitalization and/or at discharge
Eligible: All patients with confirmed AMI discharged alive.
Exclusions - Ideal candidates: Patients with evidence of bleeding on admission or during the hospitalization; history of bleeding, chronic liver disease, coagulopathy, platelet count < $100x10^9$/L; a serum creatinine level > 265 μmol (3 mg/dl); history of peptic ulcer disease or a discharge diagnosis of an upper gastrointestinal disorder; hemoglobin < 100 g/L or hematocrit < 0.30; allergy to aspirin; treatment with warfarin on admission; or metastatic cancer or other terminal illness.
Criterion: Received aspirin during the hospitalization and/or at discharge.

Timing of aspirin
Eligible: All patients with confirmed AMI who received aspirin and had documentation of the date when aspirin was first administered.
Criterion: The time (in days) from arrival at the hospital until beginning of administration of the aspirin.

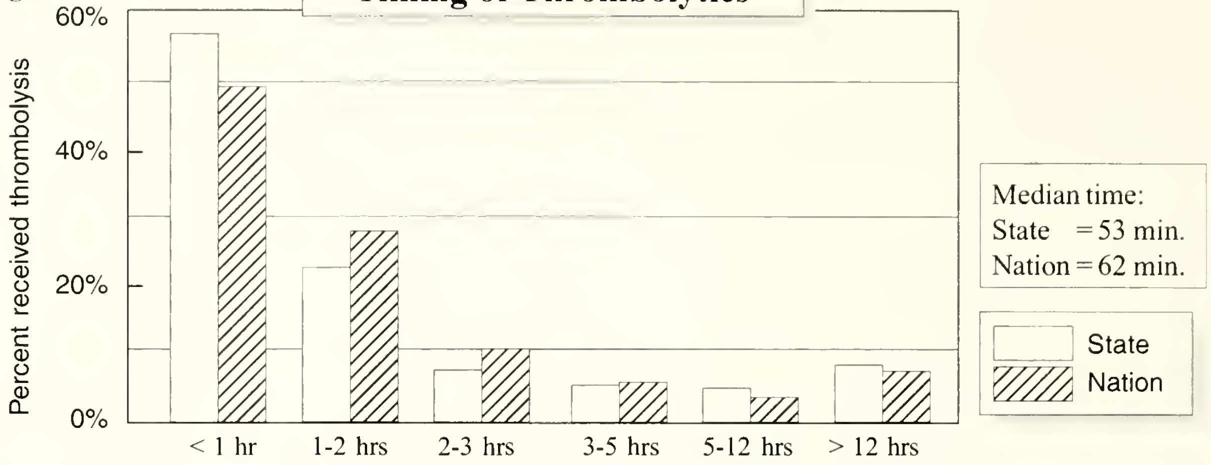
Beta blockers at discharge
Eligible: All patients with a confirmed AMI discharged alive.
Exclusions - Ideal 1 candidates: Patients with hypotension or shock during the hospitalization or systolic blood pressure at discharge of < 100 mm Hg; history of asthma or chronic obstructive pulmonary disease; bradycardia or pulse at discharge of < 50 beats per minute (unless discharged on a beta blocker); diagnosis of depression or treatment with antidepressants; dementia; conduction disorder including second or third-degree heart block, bifasicular or trifasicular block; or those at very low risk as documented by no recurrent chest pain, no arrhythmias, no previous AMI, a normal stress test, and LVEF $\geq$ 50%.
Additional Exclusions - Ideal 2 candidates: LVEF < 35%, pulmonary edema or congestive heart failure (unless measured LVEF > 50%), or treatment with insulin.
Criterion: Discharged on a beta blocker.

Angiotensin converting enzyme (ACE) inhibitors at discharge
Eligible: All patients with a confirmed AMI discharged alive with an LVEF < 40%.
Exclusions - Ideal candidates: Patients with aortic stenosis; an allergy or intolerance to ACE inhibitor; a serum creatinine > 176 μmol/L (2 mg/dl); or a systolic blood pressure < 100 mm Hg at discharge.
Criterion: Discharged on an ACE inhibitor.

Calcium channel blockers at discharge
Ineligible: All patients with a confirmed AMI discharged alive with an LVEF < 40% or documented CHF.
Criterion: Discharged on a calcium channel blocker.

Figure 1

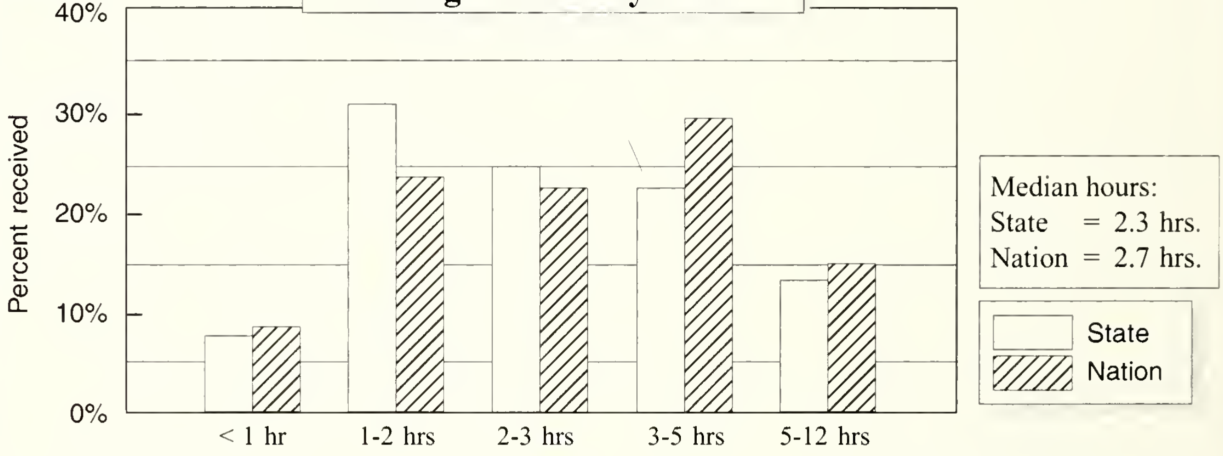
Timing of Thrombolytics



Median time:
State = 53 min.
Nation = 62 min.

Figure 2

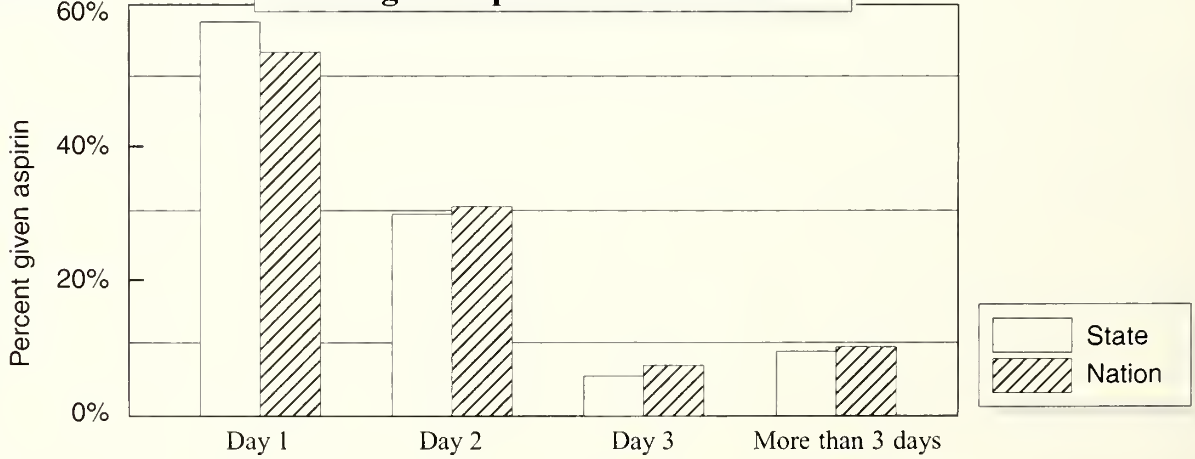
Timing of Primary PTCA



Median hours:
State = 2.3 hrs.
Nation = 2.7 hrs.

Figure 3

Timing of Aspirin Administration



Data source: Cooperative Cardiovascular Project.
Dates of data collection: National = May 1993 to July 1994.
State = April 1994 to March 1994.

Table 2. CCP Discharge Indicators

Indicators		National	Missouri
Aspirin	Eligible	51.24%	54.79%
	Ideal	77.94%	79.88%
Beta Blocker	Eligible	28.91%	24.27%
	Ideal 1	42.55%	31.75%
	Ideal 2	57.32%	39.79%
ACE Inhibitor	Eligible	23.98%	28.14%
	Ideal	55.67%	60.73%
Calcium Channel Blocker	Ineligible	27.87%	27.13%

Continued from page 600

Close to one in five Missouri Medicare beneficiaries die from their AMI by 30 days post-discharge. HCFA has also emphasized the need to increase secondary AMI prevention activities in an effort to reduce long-term morbidity and mortality. These secondary prevention activities include emphasizing improvement in each of the discharge indicators (Table 2). Missouri data indicate:

❶ 80% of all patients who are potential ideal candidates for aspirin therapy are discharged on the medication (thus one in five is not);

❶ the use of beta-blockers is below the national average;

❶ ACE inhibitors are prescribed for only 61% of potential ideal patients identified with systolic dysfunction and without documented contraindications;

❶ prescribing calcium channel blocker at discharge, in a potentially ineligible group of patients that have documented systolic dysfunction or congestive heart failure, is 27% statewide.

To re-emphasize, these discharge indicators identify major areas for secondary prevention and quality improvement initiatives related to AMI.

Despite an extensive mailing to each Missouri acute care facility in May, some physicians continue to indicate that they have not seen their hospital's individual CCP report. As a Blue Ribbon Panel of top hospital and health system executives commissioned last September by MPCRF recommended with regard to HCQIP, the long-term success of clinically-driven quality improvement efforts is a function of the extent to which hospital administration and the medical staff are in sync.[4] We strongly encourage the importance of the two working hand-in-hand.

This brief article is intended as an introduction to CCP. Additional extensive information concerning CCP awaits you within your facility. If after review of your hospital packet you have any additional questions, please feel free to contact us.

MPCRF is the federally designated Medicare peer review and quality improvement organization (PRO) for Missouri under a contract with the Health Care Financing Administration (HCFA). Conclusions and opinions expressed, as well as the methods used, are those of the authors and do not necessarily reflect HCFA policy or perspectives. The authors assume all responsibility for the accuracy and completeness of the PRO data used.

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Assessment and Diagnosis of Attention Deficit/Hyperactivity Disorder in Pediatric General Practice

Thomas D. Eppright, MD, Barry L. Stern, MA, John Reid, PhD, and Ellen Horwitz, PhD

Thorough assessment is a critical first step in the treatment of any psychiatric disorder. The need for rigorous assessment procedures is underscored for those disorders, such as Attention Deficit/Hyperactivity Disorder (ADHD) of childhood, that have a high comorbidity with other common psychiatric disorders, including childhood depression and anxiety. Extensive research regarding diagnostic procedures for ADHD has demonstrated the importance of obtaining assessment data from multiple informants and in multiple modalities as a way of confirming ADHD diagnoses. This article describes how a physician in general pediatric practice might execute a thorough initial and follow-up assessment of a child's ADHD symptomology.

The goal of this paper is to share information gleaned from 3 years of experience providing assessment and treatment services to over 230 children in an outpatient, Attention Deficit/Hyperactivity Disorder (ADHD) clinic in Mid-Missouri. It is hoped that this article will serve as a guide for clinicians, providing a systematic and empirically supported approach for both the assessment and diagnosis of child ADHD and for the selection among treatment alternatives.

The formal diagnostic criteria for Attention Deficit/Hyperactivity Disorder (ADHD) is found in the *Diagnostic and Statistical Manual for Mental Disorders*[1] (DSM-IV), the clinical reference book for psychiatric diagnoses published by the American Psychiatric Association. Children with prominent attention deficit and/or hyperactivity problems can receive ADHD diagnoses. Children meeting 6 of 9 criteria for inattention may receive the "Attention Deficit Disorder-Predominately Inattentive Type" diagnosis, whereas children meeting 6 of 9 criteria for hyperactivity may receive the "Attention Deficit Disorder-Predominantly Hyperactive Type" diagnosis. Children meeting 6 of 9 symptoms in both clusters may receive the "Attention Deficit Disorder-Combined Type" diagnosis.[1] In addition to the formal diagnostic criteria for each ADHD subtype, which are presented at the conclusion of this paper, to receive a diagnosis the child's symptoms must have developed prior to age 7, be present in more than one setting, and be associated with significant clinical impairment in social, occupational, or academic functioning.

Knowing what the diagnostic criteria are, however, does not in itself answer the question of how one truly knows when the diagnostic criteria are met. How does one know whether a child is "constantly on the go," or "is often distracted by external stimuli?" Is this information that a physician can assess in a 15-minute diagnostic interview? Is this information that a parent can provide in an objective, unbiased format? How is one to arrive at an accurate diagnostic decision? We use and recommend an approach that involves the collection of information from different sources, across different domains of the child's life and functioning, using different methods. One might call this approach multi-method, multi-informant assessment.

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Patient Name: ______________________________
Date: ______________________________

DSM-IV Attention Deficit/Hyperactivity Disorder[1]

A. Either (1) or (2)

(1) Six or more of the following symptoms of Inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

NO	YES		
0	1	a)	Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
0	1	b)	Often has difficulty sustaining attention in tasks or play activities.
0	1	c)	Often does not seem to listen when spoken to directly.
0	1	d)	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions.
0	1	e)	Often has difficulty organizing tasks and activities.
0	1	f)	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
0	1	g)	Often loses things necessary for tasks and activities (e.g. toys, school assignments, pencils, books and tools).
0	1	h)	Is often easily distracted by extraneous stimuli.
0	1	i)	Is often forgetful in daily activities.

(2) Six (or more) of the following symptoms of hyperactivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

NO	YES		
0	1	a)	Often fidgets with hands or feet or squirms in seat.
0	1	b)	Often leaves seat in classroom or in other situations in which remaining seated is expected.
0	1	c)	Often runs about or climbs excessively in situations in which it is inappropriate (In adolescents or
0	1	d)	Often has difficulty playing or engaging in leisure activities quietly.
0	1	e)	Is often "one the go" or often acts as if "driven by a motor."
0	1	f)	Often talks excessively
0	1	g)	**Impulsivity** Often blurts out answers before questions have been completed.
0	1	h)	Often has difficulty awaiting turn
0	1	i)	Often interrupts or intrudes on others (e.g., butts into conversations or games)

Circle all of b-e that apply

b) Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
c) Some impairment from the symptoms is present in two or more settings (e.g., school [work} and at home).
d) There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
e) The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

***Code* based on type:**

314.01 Attention -Deficit/Hyperactivity Disorder, Combined Type:
If both criteria A1 and A2 are met for the past 6 months.

314.00 Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type
If Criterion A1 is met but Criterion A2 is not met for the past 6 months.

314.01 Attention/Deficit/Hyperactivity Disorder, Predominately Hyperactive-Impulsive Type
If Criterion A2 is met but Criterion A1 is not met for the past 6 months.

Brief ADHD Assessment Protocol

1. **Multi-method, multi-informant assessment across settings**

   Solicite information from parents, teachers, and any other significant caregivers or individuals who regularly and extensively interact with the child. Use either the standard questionnaires discussed on this page, or, spend some time speaking with each individual, using the DSM-IV template as a guide for your questioning. One recommended approach would be to administer Child Behavior Checklists to parents and teachers, as well as the child if he or she is older than age 11, as well as the Conners ASQ (which can also be used at each follow-up visit).

2. **Interview the parents**

   You must obtain information about family dynamic issues, school or social adjustment issues for the child, developmental issues, etc., biases inherent in a parental report. This is still the best, and perhaps the only, source of information on some of the important components of the child's presenting problem.

3. **Interview the child**

   Keep in mind the type of information that one would expect from young children given their developmental stage. It is important for clinicians to have some type of personal interaction with the child. This may take the form of engaging the child in some interactive play or drawing task, or, with older children, a more formal interview format based roughly on the types of symptoms described in the DSM-IV might be appropriate. Your clinical observations, especially when supported by the quantitative questionnaire and qualitative interview data, are critical.

4. **Synthesize**

   Examine your DSM-IV template. Write notes next to the individual criteria regarding your decision and the specific pieces of information that lead you to your conclusion. Do the parents and teachers, based on the interviews and checklists, seem to concur on the majority of your symptoms within either behavioral cluster? Do those observations map onto your clinical observations? Are the child's scores in the clinical ranges on the parent and teacher questionnaires? If so, your diagnostic decision rests on much stronger footing.

Recommended Interview Questions

Questions Pertaining to the Child:

☐ Reason for referral
☐ Precipitating stressor?
☐ Domains of impairment (specific data on school, home, peer relations, etc.)
☐ Level of child's distress due to symptoms
☐ Developmental Milestones
☐ Psychiatric history
☐ Chronic medical conditions
☐ Hospitalization history
☐ Birth history
☐ Drug use
☐ Current Medications?
☐ School performance (grades, has the child had to repeat a grade, achievement test scores)
☐ Special education services?
☐ Involvement, interest and performance in activities outside the school setting

Questions Pertaining to the Child:

☐ Occupational/education histories/status
☐ Psychiatric histories (both natural parents and their extended families)
☐ Medical Histories (both natural parents)
☐ Attitudes regarding child rearing (discipline strategies, reward techniques, etc.)
☐ Child custody arrangements (adoptive, birth, foster, stepparents)
☐ Care-giving arrangements (who is the primary caregiver, etc.)

Questions Pertaining to the Teacher:

☐ What are the child's strength and weaknesses in school performance?
☐ How severe is the child's attention deficit or hyperactivity in the classroom?
☐ How disruptive is the child's behavior problem for the class and teacher?
☐ How does the child function interpersonally (get along with others, fights)?
☐ Does the teacher have any information from the outside of the classroom that might clarify the nature of the problem?

*Written consent of the parents should be obtained prior to the clinician interviewing the teacher. All behavior checklists should be given to teachers by the parent.

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Multi-Method Assessment

Why is it so important to obtain information from multiple sources? One reason is that study after study has noted the fact that different diagnostic conclusions are reached, based on the same diagnostic tools (i.e. the same interview, behavior checklist, etc.), depending on who the informant is.[2,3] In light of such strong evidence it is essential to include in your evaluation, in addition to your own clinical observations, information on the child's symptomology from both the child's parents and teachers. A second reason is that to obtain an ADHD diagnosis there must be evidence of the child's impairment in at least two different settings.[1] One way of measuring impairment across settings is to solicit information from informants who have access to the child at different times and in different places (e.g., most commonly, teachers and parents). In our clinic, for example, before the child even comes into the clinic for evaluation, we require parents and teachers, as many as are willing and available, to complete several standard questionnaires, proven in their ability to effectively discriminate groups of children with and without ADHD. One set of such scales, widely used in both clinical and research settings, are the Conners rating scales.[4] These scales, some designed for parents and other designed for teachers, are easy for the informant to complete and for the clinician to score and provide good baseline information on the child's functioning with respect to many common ADHD symptoms. Similarly, the Child Behavior Checklist (CBCL),[5] perhaps is the most widely used child assessment tool in research settings, provides valuable diagnostic information. Although these questionnaires are less powerful in predicting a given child's diagnostic status, the information they provide, especially when obtained from multiple sources, is essential in your assessment of the child's degree of impairment. In addition to providing an overall score for the behavioral dimension in question, e.g., a hyperactivity index for that child in relation to same age peers, a physician may also look at the individual items endorsed by parents or teachers to arrive at a more qualitative assessment of the child's particular areas of strength and weakness. Combining the results of parent and teacher questionnaires with some targeted questions, asked primarily of the parents, constitutes a strong, data-based, multi-informant approach to the assessment of ADHD.

In addition to these standard questionnaires, we also require that parents complete a questionnaire that describes the child's developmental history and milestones, birth complications, child, parent, and extended family medical/psychiatric history, the structure of the immediate family, the child's schooling, and a variety of other related topics. A list of suggested questions is also presented at the conclusion of this paper.

Another important piece in this multi-informant diagnostic puzzle is, of course, the child. Each child presenting to our clinic receives a 2-hour testing battery administered by a specialist in psychological test administration. This battery contains a brief (20-minute) child intelligence screen, either a brief measure of educational achievement or a standard developmental battery depending on the child's age, a brief test of visual-motor integration, and a game-like, computerized test of visual attention. While the child is completing this test battery, the child's parent(s) is being interviewed by either a staff psychiatrist or a psychologist, who then proceeds to interview the child.

At the conclusion of the interviews and testing period, information from all the different assessment modalities and multiple informants is centralized; questionnaires completed by the parent, teacher, and in some cases the child are scored, case notes based on parent and child interviews are written, and behavioral observations are documented. By the time the family returns for a 4-week follow-up appointment, these data have been combined with information from the child test battery so that the staff (psychiatric fellow, staff psychiatrist, and staff psychologist) can confer on the case. It is in this conference that all the pieces of information from the multiple sources and informants converge, and a treatment decision is made.

Not every general practice pediatrician will have the resources to complete such an assessment battery. The general

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practitioner, however, should understand the rationale for such rigorous testing. Information regarding a "gold standard" in ADHD testing, as unattainable as that standard may be in a general practice setting, provides information on the myriad issues that complicate the diagnostic picture involving ADHD. Such a test battery allows us to test hypotheses regarding the differential diagnoses of learning disabilities, visual impairments, and impairments in motor function and visual-motor integration, in children who present because of problems with either attention or hyperactivity. Being aware of these confounding issues, although it may result in greater diagnostic complexity, can only allow for a more complete understanding of each child's presenting condition and the array of associated treatment options.

In treating ADHD diagnoses, it is common practice in both research and clinical settings to employ an averaging or comparison technique. In doing so, as discussed above, there are two primary

Brief Screening Resources for ADHD

Resource	Notes	Where to Obtain
*Conners ASQ - Parent Conners ASQ - Teacher	All ages; quick, brief scale measuring basic ADHD symptoms. A quick tool that is useful for information on a child's activity level relative to his or her same-age peers. Excellent tool, because of its brevity, for quickly assessing initial symptomology at the first and all follow-up visits and/or for monitoring the effects of medication trials.	Multi-Health Systems, Inc. 908 Niagara Falls Blvd. N. Tonowanda, NY 14120
Conners Teacher	A more involved teacher report form. Provides more detailed information on several areas of the child's functioning (daydreaming, hyperactivity, anxiety, concentration), and is thus slightly more specific then the Conners ASQ. It takes approximately 15 minutes to score.	
* Child Behavior Checklist	A well-normed measure for assessing child behavior disorders. Parent, child (ages 11 and older) and teacher checklist forms available, as well as computerized scoring system that prints out profile of scores for various types of functioning (depression, somatic complaints, attention problems, aggression, delinquency, etc., as well as general internalizing and externalizing behavior scores, and a total score). Highly recommended because of the computerized scoring (data can be entered and the program run by administrative staff), and the general quality of the instrument.	T.M. Achenbach University of Vermont 1 S. Prospect St. Burlington, VT 05401
Home and School Situations Questionnaires ADHD Rating Scale	Two short checklists each of which are excellent tools for assessing children's response to either behavioral or psychopharmacological intervention. Administer to teacher and parent at the time of the initial consult, and readminister several weeks after the initiation of or any change in an existing treatment.	In Barclay, RA *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*, 1990, Guilford Press, N.Y. (Scales are found in the accompanying workbook.)

*Highly recommended for use in general pediatric practice.

factors to consider. First, one must compare information on the child's behaviors across situations. Second, one must compare information on the child's behavior across informants (e.g. parent, teacher, clinician, etc.); is there agreement regarding the child's problematic behaviors across a variety of informants, each of whom has access to the child's behaviors in different settings? Again, perhaps the most important procedural point in making ADHD diagnostic decisions in clinical settings involves soliciting information on the child's behaviors from these multiple sources.

Treatment

Once you have a strong sense that a given child does in fact meet diagnostic criteria, what are your options for treatment? We have found that these options fall into three general categories. One common approach, particularly for families in which the patient is their first child, or for families in which the parents have limited parenting skills and/or experience working with young children, is to refer the family for some form of psychotherapeutic family counseling or psychoeducational services designed to increase knowledge of child developmental issues. A variety of therapeutic programs designed to enhance parenting skills and parent child communication and interaction are often available through local community mental health centers, hospitals, and other community services organizations. Such a referral constitutes approximately 50% of the treatment recommendations at out clinic, and in many cases can yield significant benefits for both parents and children. The link between parenting behaviors and child behaviors is well documented, and for cases in which the parenting skills are deficient, particularly with younger children, a referral to family therapy services is entirely appropriate.

A second treatment option, commonly used in conjunction with family-based interventions, is school-based intervention. These interventions can assume many forms, including consultation with teachers regarding the child's strengths and weaknesses and the extent to which classroom modifications might improve the child's functioning, consultation with parents and/or teachers on the development of individual education plans (IEPs), referrals for school-based counseling services, and referrals for learning disability assessments.

A third option is psychopharmacological intervention. Research has shown a variety of psychostimulant medications, in particular, Ritalin (the most widely studied and commonly used psychostimulant), Dexedrine, and Cylert, to be effective in the medical management of ADHD. Several important points should be noted with respect to the efficacy of psychostimulant medications. First, medications should generally be prescribed only after both family- and school-based behavioral interventions have been attempted. Similarly, medications should not be prescribed unless these same behavioral interventions are ongoing. The research on the long-term effects of psychostimulant medications does not reveal consistent long-term improvements in terms of social, vocational, or academic functioning when psychostimulants are used as the sole method of treatment.[6] Furthermore, although approximately two-thirds of children respond positively to psychostimulant medication, the problem behaviors of only a fraction of those children reduce to normal levels in response to medication alone. Also, for many children medications are not administered outside the most problematic settings, i.e., at home after school-hours or on vacations). Nevertheless, parents and children must still learn to manage the problematic child behaviors during those times. Finally, research has shown that when combined with behavioral interventions, both low and high doses of the psychostimulants yield similar effects, thus allowing for reduced dosage levels.[6] Thus, for these and other reasons, psychostimulant treatment should generally be prescribed in conjunction with family-and/or school-based behavioral interventions.

All stimulant prescriptions should start at the low-end of the dosage range and be titrated according to the child's response. Some children experience adverse reactions to psychostimulant medications, including sleep and appetite disturbances, stomach aches, and agitation. It should be noted, however, that up to 20% of children who respond poorly to one of the psychostimulant

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ADHD MEDICATIONS FACT SHEET[7]

	Medication	Indications/Dosage	Effects to Monitor
First Line Medications: **Psychostimulants**	Ritalin	Peak effect two hours after ingestion. Total effect of each dose lasts approximately 3-6 hours. Particularly good for addressing attention problems. Chewing pills may potentiate dose. **Indications:** Not approved for use in children under 6 years of age. **Dosage Schedule for treating ADHD:** Usual optimal dose is between 0.3 and 0.7 mg/kg given 2 to 3 timess daily. Total daily range is 0.6 to 2.1 mg/kg/day[8] **Dosage forms:** Available in 5, 10, or 20 mg. tablets. Sustained-release (SR) 20 mg. tablet, although less effective, is available if mid-day administrations is problematic.	Agitation, stomach aches, loss of appetite, nausea, sleep disturbance. Check for the exacerbation or development of motor tics at each visit. Always monitor blood pressure and pulse, especially early on as dosage is titrated. Can produce small but significant decreases in weight and growth. These can be minimized by drug holidays. Height and weight should be monitored at least 2-3 times yearly.
	Dexedrine:	Small bell-shaped curve of effectiveness as Ritalin, although many believe it is more potent. **Indications:** Not approved for use in children under 3 years of age. **Dosage Schedule for treating ADHD:** Usual optimal dose is between 0.15 and 0.5 mg/kg for each dose, administered 2 to 3 times daily. Total dose range 0.3 to 1.5 mg/kg/day.[8] **Dosage forms:** 5 and 10 mg. tablets. SR tablets in 10 and 15 mg.	“
	Cylert:	Longer acting (approximately 10 hours). Thought to have the least potential for abuse. **Dosage forms:** 18.75, 37.5, and 75 mg. tablet.	Same effects noted above, although action is more like a sustained release tablet. Also check for development of chemical hepatitis.
Second Line Medications: **Antidepressants**	Imiprimine	**Dosage:** Start at .5 mg/kg. Maximum dosage of 5 mg/kg (although most patients require much less medication). Usual total daily dosage of Imipromine usually remains below 2.5 mg/kg. Use plasma levels to monitor toxicity: 150-300 ng/ml	**Before starting:** Routine Evaluation: weight, blood pressure, pulse, Baseline EKG looking for heart block. Guidelines for EKG change: EKG and blood levels at each mg/kg increase in dose; P-R interval not to exceed .21 second; Resting HR should be less than 130 beats per minutes; QRS interval should not exceed .02 seconds more than the baseline interval.
Third Line Medications:	Clonidine	Useful for reducing agitation and hyperactivity symptoms. **Dosage:** 0.05 mg/day is starting dose. May need to titrate to maximum dose of 0.2 to 0.3 mg/day in 3-4 divided doses.	Hypotension/Dizziness. If used in conjunction with psychostimulants, obtaining baseline cardiac and EKG data is recommended. **Effects to monitor:** Caution should be used when used inconjunction with psychostimulants, especially Ritalin.

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medications have a positive response to another psychostimulant medication. One common tactic for avoiding the lack of appetite that sometimes is associated with psychostimulant use is to administer the dose after meals. For cases in which the response to the psychostimulants is poor, a trial of a tricyclic antidepressant (e.g. Imiprimine), which has been shown to be effective in treating ADHD, might be indicated. Finally, whereas Ritalin has been sown to be useful in the treatment primarily of the inattention symptoms of the disorder, low-doses of clonidine, an anti-hypertensive drug, have been shown effective in reducing more acute hyperactivity/agitation symptoms. One obvious side effect to monitor with the administration of clonidine is hypotension.

Regardless of which type of treatment is chosen, ongoing monitoring of patient progress is required. We recommend, for example, a follow-up visit at least 4 weeks after the start of a medication trial, and encourage parents to contact the clinic sooner in the event that their child experiences some adverse reaction to the medication. During this interim period it is recommended that both parents and teachers keep daily records of child behaviors (number of assignments completed, degree of accuracy in schoolwork, compliance with problematic household rules, etc.). It is particularly useful if these records can be linked to times when the child is on and off medication. For cases in which family- and or school-based interventions alone are the recommended option, the time before a follow-up visit is typically somewhat longer than the previously recommended 4 weeks.

Conclusion

Although the answers to the assessment and treatment questions involving ADHD are not clear-cut, one thing is clear; vague clinical intuition will not suffice in making accurate diagnostic and treatment decisions, especially when the diagnostic picture is complicated by the factors discussed above. In summary, assess across situations and informants, consult with colleagues whenever possible, and consider the environmental factors coming to bear on each individual child, as well as the family's strengths and weaknesses, in making your decisions.

Appreciation is expressed to the Children's Miracle Network for funding and to Dr. Javad Kashani for his helpful comments.

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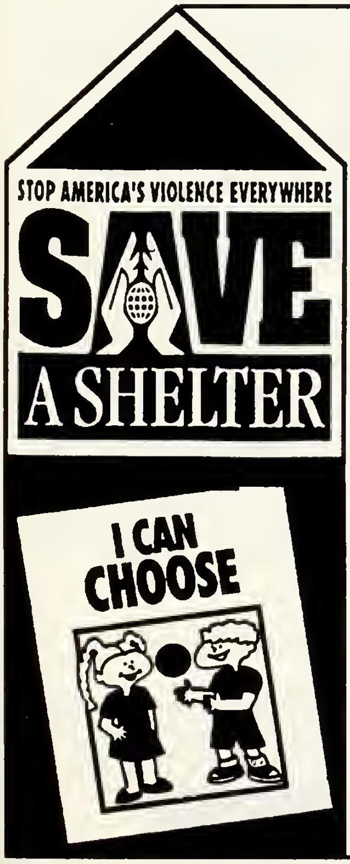

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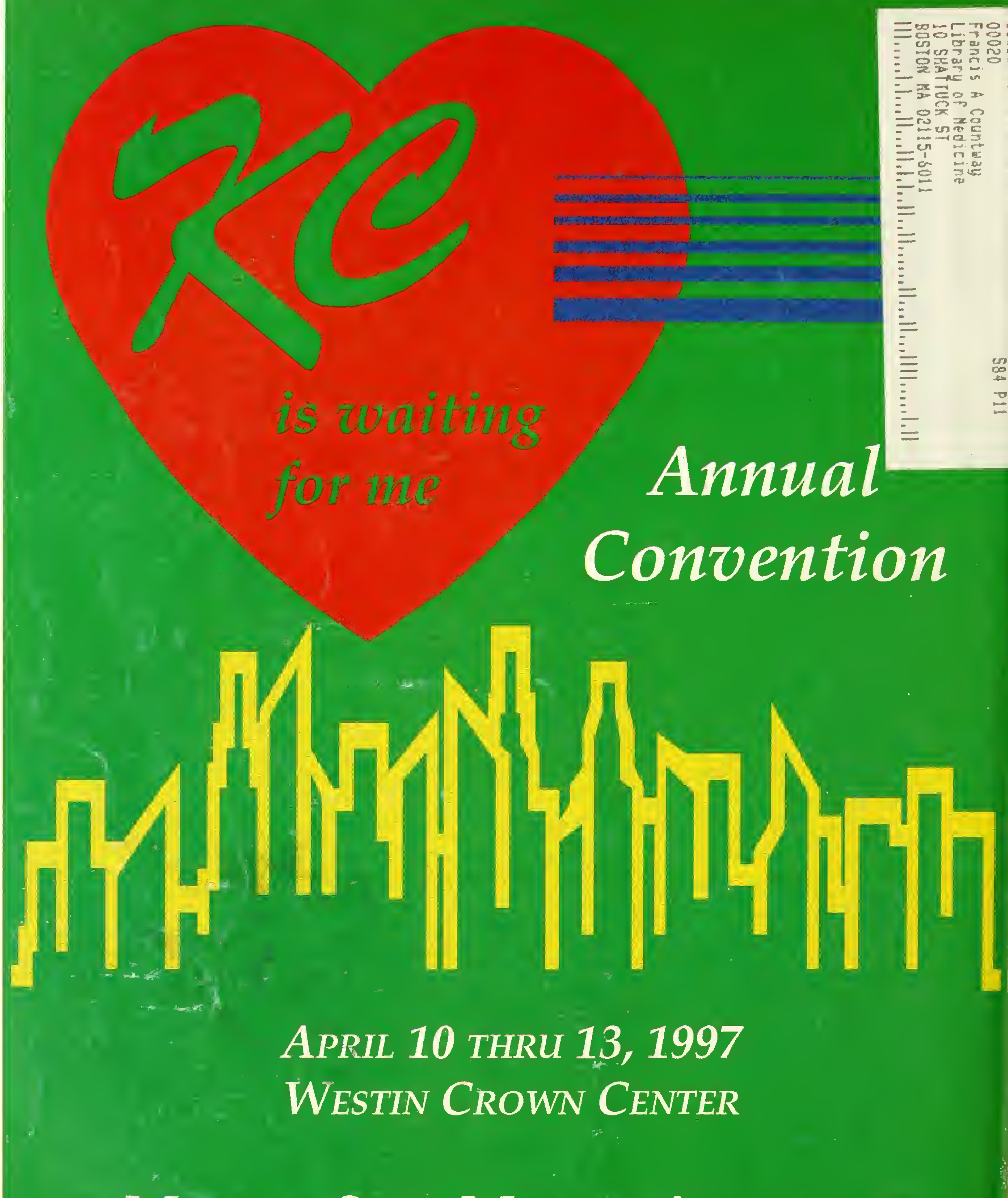

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Journal of the Missouri State Medical Association
October 1996

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- ☐ **Avoiding the Claim of Patient Abandonment**
- ☐ **Problems with Rural Hospitals and Physician Employees**
- ☐ **MC+ Patient Satisfaction Survey**
- ☐ **Health Care Development As An Emerging Industry**
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On the Cover:
"Indian Summer Landscape" is an acrylic painting by Terry Martin. Mr. Martin is an associate professor of fine art at William Woods University in Fulton, Missouri.

Editor's Desk

Walk the Walk, If You Talk the Talk

J. Regan Thomas, MD, Editor

"Actions speak louder than words;" "Practice what you preach" are two more common messages asking us to do what we say. Recently I hear the phrase, "If you talk the talk, then you should walk the walk" used frequently. That one is a bit more obscure for me, but I think the message is the same. Perhaps during an election year we all tend to tire of the rhetoric and wonder if anyone really can or will act on their words.

Politicians are not the only ones who seem to make more noise than action. Lots of people seem to jump on the proverbial bandwagon and give lip service to the cause of the moment without really providing service for the solution. A prime example is wearing a red ribbon for AIDS awareness. Those ribbon emblems are particularly prevalent at Hollywood type celebrity events and award shows. I am very suspicious that many of the media or celebrity types I see sporting those ribbons are more concerned about making a fashion statement than taking steps to help fight AIDS. Have they really participated in any activity specifically aimed at treating or preventing AIDS? Have they donated money to AIDS research? Are they knowledgeable about the disease or present steps being taken to deal with it? Have they contacted their elected officials about their ideas for supporting research or public health AIDS prevention?

Have they really participated in any activity specifically aimed at treating or preventing AIDS? Have they donated money to AIDS research? Are they knowledgeable about the disease or present steps being taken to deal with it? Have they contacted their elected officials about their ideas for supporting research or public health AIDS prevention?

Wearing the ribbon is fine, but the point is that it is not enough. It is trendy to wear the ribbon right now. It's a shame if the ribbon fad passes and the wearers did nothing else to deal with the AIDS disease. It reminds me of some of the people I met as a student who were part of the "anti-war in Vietnam" movement. There were of course genuinely concerned and dedicated individuals on both sides of the issue, but there were also a lot of people who were part of the fad. There were people who enjoyed looking the part and attending the rallies but seemed to me to be more interested in the music and the "scene" than the issues regarding the war. Whatever their convictions, I hope they were as concerned about the post war issues of orphans, displaced children and refugees as they were when it was fashionable to be part of the "movement."

A similar issue relates to the public relations calendar campaigns. These include thing like National Vegetarian Awareness Month. In fact, that is this month! I hope you are eating your broccoli and lima beans this month.

Who decides on these dates? What are the criteria and which ones are official? What do you have to do to get a whole month versus a week or day? What did the vegetarians do to get Vegetarian Awareness Month that pork fans didn't do and only got National Eat More Pork Week?

It seems that there are so many of these dates established that they have very little meaning. Do the people who establish these dates really do anything more than have it placed in the Congressional Record by their name or perhaps get their photo in the organizational newsletter? Some of the dates appear to overlap. Wouldn't it make more sense to combine resources and energies? For example, this is Family Health Month. It is also Healthier Babies Month. Maybe the babies should be part of the Family Health Month. It is also National Family Sexuality Education Month, interestingly there seems to be a trend here. It is Spinal Health Month this month, but it is also National Spina Bifida Month. It seems these could be coordinated in some way or is it more important to have your own month?

October is National AIDS Awareness Month. I am hoping that people become aware that it takes more than wearing a ribbon to make a difference.

The question remains, do these activities really make a difference or are they just momentary talk. Do the people who in some way participate or observe these dates really accomplish a goal or is it simply "talking the talk" without "walking the walk"? You might be interested to know that October is also Lupus Awareness Month, Healthy Lung Month, National Liver Awareness Month, National Brain Injury Awareness Month, National Breast Cancer Awareness Month, National Sudden Infant Death Syndrome Awareness Month, National Depression Education and Awareness Month, National Disability Employment Awareness Month, and National Dental Hygiene Month.

There is one more. October is National AIDS Awareness Month. I am hoping that people become aware that it takes more than wearing a ribbon to make a difference. MoMed

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I Gave at the Office

Frederick Hahn, MSMA Immediate Past President

It is often pointed out that physicians are very "tight." They indeed are not noted for being either big givers of time or money to community organizations. In years past most physicians honestly could say they had contributed to the community through all of the gratis clinical work they offered voluntarily and with a significant degree of pride.

Today, however, voluntary contributions have been replaced by mandatory adherence to fee schedules thrust upon physicians on a take it or leave it basis by the various forms of managed care, Medicare and Medicaid. The margin which was previously allowed physicians to voluntarily contribute has been taken away by this same managed care.

Unfortunately, that margin is no longer redirected to the care of those who are needy in our communities. Instead, it is pipelined to managed care headquarters which are not only cities away, but often many states away.

The funds which are siphoned off are not being directed to the needy in other communities either. Rather, it is pulled out of our communities and transferred to the "bottom line" entries of speculative investors and for outrageous salaries and bonuses commanded by those who unscrupulously manage for the bottom line investors.

Where are the Doctors (and other professionals)?

Few physicians, who actually live in the community where they practice, try to participate in business, civic and service organizations of the community. I have wondered for years, "where are all the professionals?"

Recently, a family member serving on the board of a not-for-profit service institution worked an appreciation dinner recognizing "major contributors." As I listened to the accounting of all those who attended, I gained confirmation of an insight which I have periodically entertained but just as quickly forgotten.

Who are these folks?

Attending was the president of a large regional bank conglomerate, the comptroller of a multinational communication company, an administrator from a large hospital chain, a successful retail owner with accessible promotional items from medical wholesalers and so on down the line. There were no "small fries" to be found.

Two points all of a sudden became clear. First, those who had painfully contributed their "two mites" were not being honored. Second, not any of the honored "contributors" disturbed their own personal budget in the least.

Further Reflection

I reflected a bit further into my own personal experience. I remembered the "tireless contributors" who were always available from mid-morning or mid-afternoon meetings at the Chamber of Commerce and other similar organizations. The majority of these "courageous workers" always seemed to be available from 8 a.m. to 5 p.m. I recall now that I would have to say, "you may have just about any morning before work or any evening after work, but without lengthy prior planning my day times are committed." The majority opted for morning or afternoon meetings.

I realize that what I as a young man thought was "real dedication" was in reality saying, "we are happy to do this on our company's time, but off duty hours are ours."

A Corollary

I expressed a corollary of this reality in a Metropolitan Medical Society Bulletin "President's Page" in 1986. There I described the inversion of a schematic pyramid of a professional office and that of a business organization. In a solo physician's office, the physician is the only "producer." When he or she is gone, no work is done. In contrast, industry workers form a broad production base. The CEO can leave for an extended period of time and manufacturing continues.

If he or she brings back a good idea from a resort conference then the whole company profits from the absence.

Lessons Learned

During my first tour on the Chamber of Commerce Board, three to four years into my practice, I experienced the difficulty of a private practitioner running with a panel of CEOs. At that time in the 1970s, I was making $17,000 to $20,000 per year.

The board collectively elected to institute a large holiday festival. It was the start up year of what was to become an annual event and was anticipated to be a touch and go financial effort. The Chamber at the time was operating on a hand to mouth budget. While we prayed for nice clear weather, we experienced an unseasonably cold rainy three days. A $10,000 deficit stared our board in the face.

In an emergency session, the chairman asked, "How are we going to handle this loss?" A successful car dealer sitting down the table from me volunteered, "I will give $500." Each board member in turn volunteered to do the same as the "wave" came toward me around the table. I couldn't say, "I don't have it." So I too affirmed I would give $500.

With a new office start up, school debts and two kids now in junior high, I didn't have "it." I did what I had to do. I went to the bank and added to my indebtedness. Now I realize that for the most part, few of the board members contributed anything from their own personal budget.

To be a part of the community today is no different. However, the "hit" may now be $10,000."

Fight or Flight

I have at times looked about me in our metropolitan suburb and queried, "Where are the Doctors?" Well, like about any other large community, they have fled to "Pill Hill." Its location varies from community to community. In Kansas City it is across a stateline. When I have tried to do a reasonably accurate count, I find that no more than 25% of the doctors stay to fight it out in our own community.

Bottom Line

Bottom line, there are many bottom lines. First, when professionals are asked to participate individually, it is disheartening that what one contributes personally may be compared to much larger industries.

Second, the modus operandi of a professional work pyramid is inverted to that of most other businesses and industries. Time contributed by professionals is a true sacrifice in lost production, while corporate administrators are paid to "volunteer."

Third, we physicians have in greater part elected to leave our practice arena isolated and insulated from those who support us. I truly believe this is a debit to our professionalism.

In Summation

As professionals in medicine, our history is giving to and caring for those who place their health in our hands. Perhaps the best we have to offer are the services and relationships established in our offices.

However, as a committee of at least one, I believe that what we give at the office can be enhanced by the additional service we contribute to our communities. Despite the challenges I perceive, I encourage the fight to serve instead of the flight to obscurity. **MoMed**

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Radiology Quiz #8

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

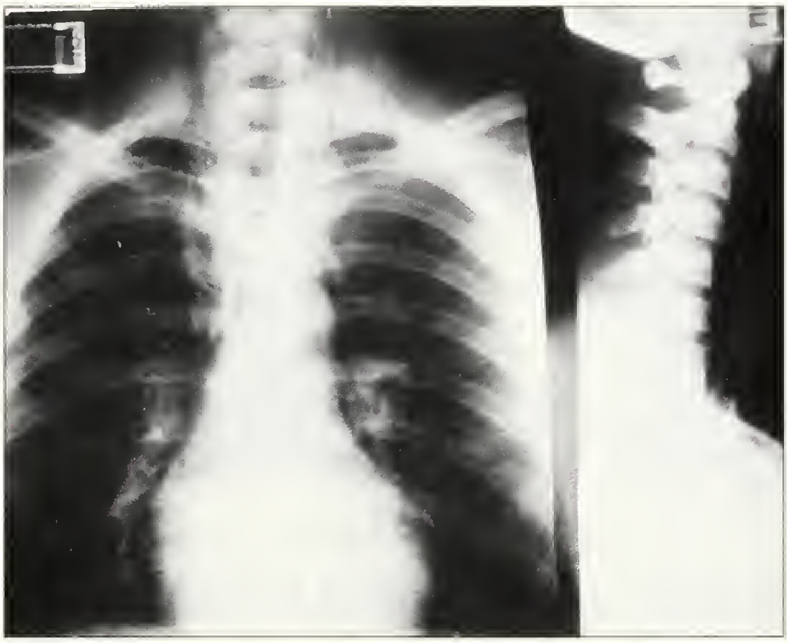


Figure 1

An 18-year-old man received a direct blow to the anterior neck while riding a personal watercraft. You are shown an upright chest film and a lateral neck film (Fig. 1).

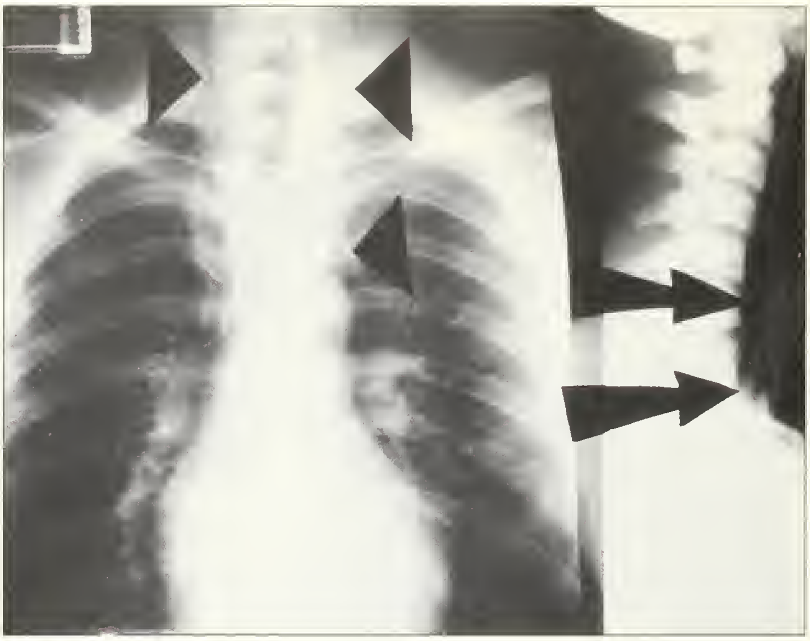
What is the diagnosis?

a. pneumothorax and subcutaneous emphysema
b. esophageal rupture
c. neck cutaneous laceration
d. airway injury

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.



Repeat Figure 1

ANSWER: d. airway injury.

The chest film (repeat Fig. 1) shows streaky air collections (arrowheads) in the mediastinum and lower neck. No pneumothorax is seen. The lateral neck film shows marked subcutaneous air (arrows) throughout the neck. The presence of pneumomediastinum and subcutaneous emphysema in the neck in a trauma patient without a visible pneumothorax indicates airway injury until proven otherwise (Option D is the correct answer). Emergency laryngo-tracheoscopy was performed, showing laryngeal fracture with marked hemorrhage and edema.

Option A, pneumothorax is incorrect since no pneumothorax is visible on the upright chest film. Pneumothorax is a common cause of subcutaneous emphysema in the chest and neck, due to dissection of air from the pleural space into adjacent soft tissues, especially with rib fractures.

Option B, esophageal rupture is a very uncommon result of blunt trauma. Esophageal rupture most commonly results from penetrating foreign bodies, complications of endoscopy or dilatation, or due to forceful vomiting (Boorhaeve's syndrome).

Option C, neck laceration is a possible cause of subcutaneous emphysema, but would not result in this degree of emphysema or pneumomediastinum unless there was penetration of the trachea or esophagus. Also, a skin laceration was not apparent in this case.

References

1. Taveras and Ferrucci, Editors. *Radiology: Diagnosis-Imaging-Intervention.* Lippincott 1994, Vol. 3, Chapt. 88, p. 5-7.

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In Memoriam

David W. Hall, MD

David W. Hall, MD, 70, Springfield, Missouri, died September 13, 1996. Dr. Hall received his medical degree at the University of Louisville in 1952. He completed is internship at Kentucky Baptist Hospital and an internal medicine residency at Kansas City General Hospital. In 1954 he started his private practice in Springfield, Missouri. He also served as the doctor for the Springfield School District and as a clinical doctor for Southwest Missouri State University Health Center. In 1970 he was a member of the first group of doctors to earn Board Certification in the new specialty of Family Practice. He was an active member of the medical staffs of St. John's Regional Health Center, Cox Medical Center, and the former Springfield Community Hospital, where he served a term as chief of staff. In 1976 he was elected president of the Greene County Medical Society. He was active in the Flying Physicians Association. He served as president and chair of the Board of the Missouri Academy of Family Physicians, was a Councilor to the Missouri State Medical Association and a Missouri Delegate to the American Medical Association. After 42 years of medical practice he retired in 1995.

Edwin J. Casey, MD, 87, Richmond Heights, Missouri, died August 24, 1996. Dr. Casey received his medical degree at St. Louis University in 1933. He interned at St. Mary's Group Hospitals and then entered private practice, and served as a Camp Surgeon with the Civilian Construction Corps (CCC). Dr. Casey received a master's degree in Ophthalmology at St. Louis University in 1941 and was appointed Senior Instructor in Ophthalmology. During World War II, he served as an Army doctor in New Guinea. Following the war, he returned to St. Louis University and became an associate clinical

Continued on page 634

Membership Notes

Phillip E. Cryer, MD, Irene E. and Michael M. Karl Professor of Endocrinology and Metabolism and director of the Division of Endocrinology, Diabetes and Metabolism, at Washington University School of Medicine, has been elected president of the American Diabetes Association (ADA). Dr. Cryer, who is also director of the General Clinical Research Center at the medical school, has been an active volunteer for the ADA since 1975. Prior to his election as national president, he served as president of both the Missouri Affiliate and the St. Louis Chapter of the ADA. He also served on numerous national committees and was the editor of Diabetes, the association's leading scientific journal. In 1994, Dr. Cryer received the Banting Medal for Scientific Achievement. The award honors highly meritorious career achievement in the field of diabetes research. It is the highest scientific award given by the ADA and is presented annually to an individual who has made significant, long-term contributions to understanding diabetes, its treatment and prevention.

Buchanan County Medical Society Past Presidents **William Gondring, MD,** an orthopedic specialist, and **Jay McMillen, MD,** internal medicine specialist, recently returned from a nine-day medical mission to Honduras. They were part of a St. Joseph medical team that served three clinics which are normally unfunded and not staffed. The medical team would like to raise funds for a year's worth of supplies and a stipend to create a regular rotation of St. Joseph-area medical providers to staff the clinic. Contributions can be made to the Heartland Honduran Medical Clinic Fund in care of the Heartland Foundation.

Robert W. Thompson, MD, assistant professor of surgery at Washington University School of Medicine, received a four-year grant from the National Heart, Lung and Blood Institute for a research project titled, "Molecular Mechanisms of Aneurysmal Degeneration."

*MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to **Missouri Medicine**, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

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In Memoriam

Edwin J. Casey

Continued from page 632

professor. Dr. Casey helped establish and supervise the clinical Ophthalmology program at St. Louis University Hospitals and at Cardinal Glennon Children's Hospital. He retired in 1975 and was named an Emeritus Professor of Clinical Ophthalmology. He also operated a private practice with an office in St. Louis and a second in Illinois. Dr. Casey had been on the staffs of St. Mary's Group, Cardinal Glennon Children's Hospital, DePaul Hospital, St. Louis University Hospital, the old Missouri Pacific Hospital, St. Elizabeth's Hospital in Granite City, and St. Mary's and Christian Welfare hospitals. He was a member of the Missouri State Medical Association and the American Academy of Ophthalmology and Otolaryngology.

Forest H. Coulson, MD, 81, Shreveport, Louisiana, died August 23, 1996. Dr. Coulson received his medical degree at the University of Iowa in 1940. He was elected to Alpha Omega Alpha. Dr. Coulson completed his internship and residency in internal medicine at the University of Iowa. As a resident he researched blood preservation, transport and banking, with Dr. Elmer DeGowin. During World War II he and Dr. R. Hardin, later Dean of the University of the Iowa Medical School, established and operated the blood bank in the European Theater. Drs. Coulson and Hardin trained 500 people to care for the personnel of five armies, for which they received the Legion of Merit and a commendation from Gen. Eisenhower. Dr. Coulson was CEO at the 127th Station Hospital and was in charge of all technical operations of the blood bank. After the war he returned to Burlington, Iowa, and established his practice in internal medicine. He was president of the Des Moines County Medical Society, the Iowa Clinical Medical Society, and served as chief of staff at Burlington and Mercy hospitals in Burlington. In 1971 he relocated to Cape Girardeau, Missouri. He was an active staff member at St. Francis Hospital, Southeast Missouri Hospital, as well as Medical Director of Chateau Girardeau Retirement Home. Dr. Coulson was a member of the Cape Girardeau County Area Medical Society, Missouri State Medical Association, American Medical Association, American Society of Internal Medicine and American Diabetes Association.

John T. Lawton, MD, 71, St. Louis, Missouri, died September 6, 1996. Dr. Lawton received his medical degree at St. Louis University in 1948. He served in the Army Medical Corps during the Korean War. Dr. Lawton was in private practice in the St. Louis area for 40 years. He was on staff at St. John's Mercy Medical Center in Creve Coeur and a former president of the medical staff and director of the coronary care unit at DePaul Health Center in Bridgeton. He was also an instructor in internal medicine at St. Louis University Medical School He retired in 1990. In 1972, he was made a Knight of the Holy Sepulcher by Pope Paul VI for his professional care of St. Louis priests who served in Bolivian missions. He was a former head of the Catholic Physicians Guild. Dr. Lawton was a member of the American College of Chest Physicians, American College of Physicians, American Society of Internal Medicine, and American Society of Clinical Pharnacology & Therapeutics.

Robert W. Lohr, MD, 70, Town and Country, Missouri, died August 18, 1996. Dr. Lohr received his medical degree at St. Louis University in 1954. He was on the staff at Salem General Hospital in Salem, Missouri, when he retired in the 1980s. In the 1970s and 1980s, he practiced at Christian Hospital Northeast, in North St. Louis County, and at Christian Hospital Northwest, in Florissant. He was a member of the American College of Radiology and the Radiological Society of North America.

Rudy Ruhling, MD, 81, Punta Gorda, Florida, died August 23, 1996, of leukemia. Dr. Ruhling received his medical degree at Loma Linda University, Loma Linda, California, in 1941. He was in private practice in Webster Groves for 40 years before he retired in 1990. Dr. Ruhling was also an instructor at St. Louis University. He was formerly on the medical staff at Deaconess, Lutheran and St. Louis University hospitals. Dr. Ruhling was a member of the American Academy of Family Physicians.

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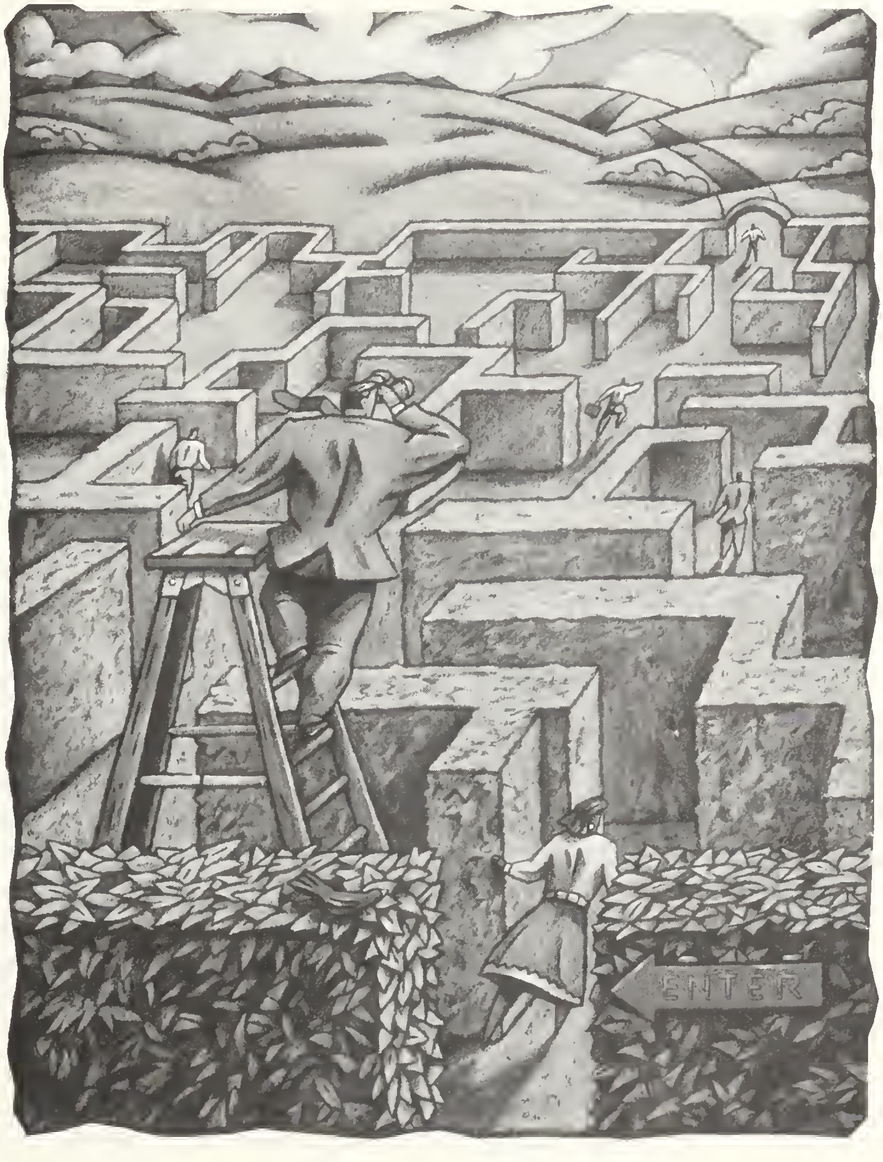

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Avoiding The Claim of Patient Abandonment

Sally Thieman, BSN, JD

A physician's chronic dialysis patient once again threatens him, his staff and generally frightens everyone. The diabetic patient refuses to follow her doctor's advice, continues to abuse illegal drugs and frequently demands appointments for a myriad of unsubstantiated complaints. Are the physician and his or her staff duty-bound to continue to treat individuals regardless of their behavior and noncompliance?

The relationship between a physician and his or her patient is a special one. Ideally it is built on mutual trust and respect. Unlike most contractual relationships wherein the parties are theoretically on equal footing, the patient in this relationship is often more vulnerable due to illness, fear, and less knowledge, clearly in need of the physician's services. The law refers to the relationship as a fiduciary one, recognizing the patient's reliance on the physician and the duty of the physician to act in the best interest of the patient.

As with all relationships between human beings, the physician-patient relationship is sometimes flawed. There may be times when the relationship becomes intolerable to one or the other party. The purpose of this article is to discuss the manner in which the established physician-patient relationship may be terminated by the physician without exposing him or her to liability for abandonment of the patient.

The Claim of Abandonment

Abandonment is defined as the unilateral termination by the physician of the physician-patient relationship without adequate notice to afford the patient the opportunity to obtain equally qualified replacement care and at a time when medical care is still needed.[1]

Obviously, the existence of a physician-patient relationship is crucial to sustaining a claim for abandonment. If this professional relationship has not been established, no claim for abandonment can be sustained. A physician in private practice has the right to refuse to accept a new patient, assuming there are no other contractual obligations requiring acceptance, without incurring a claim of abandoment.[2]

Ordinarily, once the relationship of physician and patient is initiated, it continues until the patient is no longer in need of the physician's services or until the relationship is ended by mutual agreement. However, situations do arise wherein either party may feel the relationship needs to end.

The patient may become dissatisfied. The physician-patient relationship may be terminated at any time by the patient. If the patient chooses not to return to see the patient's physician despite the physician's continued willingness to treat the patient, there can be no claim of abandonment.[3] If the physician feels the patient is in need of continued care, the physician has the duty to warn the patient of this need and to provide the patient's designated subsequent treating physician with adequate information for the continued treatment.[4] For his or her own protection, the physician should write a letter to the patient documenting his or her discharge and informing the patient in writing of the need for continued treatment and documenting the patient's understanding of the ramifications of his or her refusal of treatment.

Physicians may also wish to terminate the professional relationship with a patient although the patient continues to need medical care. The physician may feel he or she cannot interact effectively with the patient. The patient may refuse to cooperate with the physician or follow directions. The patient may be disruptive to other patients or staff. Although the law speaks often of the duty a physician owes to his or her patient, this duty is not without limits. The physician can withdraw from the patient's care as long as certain steps are taken.

Avoiding the Claim of Abandonment

Good communication skills and documentation of conversations are key to avoiding misunderstandings which may result in a patient filing any claim, including a claim of abandonment. Any limitations which will be placed on the physician-patient relationship should be made clear to the patient at the outset.

For example, a specialist should satisfy himself or herself that the patient understands the limited role of the specialist. If care is to be limited by a payor to a certain number of days or visits, this limitation should be explained and the discussion documented in writing at the initial visit. The physician is entitled to determine the frequency of visits with the patient as long as the frequency meets the standard of care. Refusing to see a patient more often than is necessary does not constitute abandonment.[5]

When the physician determines that it is necessary to terminate a relationship with a patient, he or she must notify the patient, allowing the patient adequate opportunity to find replacement care.[6] There is no definition for the amount of notice required. What constitutes reasonable notice will vary depending on the facts and circumstances, including the patient's current medical condition. The physician should consider the availability of other physicians to treat the patient's disorder and how acutely the patient is in need of care.

The reasons for the termination should be clearly documented in the chart. The notice to the patient of the termination should be in writing, clearly stating that the relationship will be terminated as of a definite date and expressing the physician's willingness to see the patient up until that time. The following is the text from an American Medical Association form letter notifying a patient of termination of a professional relationship:

I will no longer be able to provide medical care to ______________________________(you or your children or as the case may be). If you require medical care within the next _____days, I will be available, but in no event for more than _____days.

To assist you in continuing to receive medical care for ______________________________(yourself or your children or as the case may be), my office will make records available to a new physician as soon as you authorize us to send them to that physician.[7]

In action for abandonment, the plaintiff (patient) must prove that the alleged abandonment was the proximate cause of injuries that the plaintiff claims to have suffered as a result. There is no requirement that the physician find replacement care for the patient. However, doing so could diminish or eliminate any opportunity for the patient to make an abandonment claim. If other adequate care was available but the patient chose not to participate in that care, the patient would be unable to claim that the termination caused the alleged damages. Without the causal link, the patient cannot sustain his or her claim.

Summary

Because of the fiduciary nature of the relationship, a physician cannot precipitously "call it quits" when the physician-patient relationship becomes untenable. However, termination of the relationship with adequate notice, clear communication, documentation and attention to the patient's continuing needs can successfully avoid any liability for patient abandonment.

References

1. *Reid v. Johnson*, 851 S.W. 2d 120 (Mo. App. E.D. 1993); 3 P.O.F. 2d *Abandonment of Patient* § 1 at 123.
2. 3 P.O.F. 2d *Abandonment of Patient* § 2 at 124.
3. *Reid*, 851 S.W. 2d at 122.
4. 3 P.O.F. 2d *Abandonment of Patient* § 3 at 127.
5. 3 P.O.F. 2d *Abandonment of Patient* § 2 at 126.
6. *Reid*, 851 S.W. 2d at 121; 61 Am Jur 2d Physicians and Surgeons § 235 at 366.
7. 15 Am Jur Legal Forms 2d, Physicians and Surgeons § 202:64.

The Author

Sally Thieman, BSN, JD, is a nurse attorney and the risk manager at Saint Luke's Health System in Kansas City, Missouri.

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Jeff Howell, MSMA Director of Field Services

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The federation of organized medicine continually strives to reach common goals, but we are continuously competing for membership dues. There is absolutely no reason why a physician should join one level of the federation and ignore the others. The federation is a smooth running engine and you're the oil. Without you our parts eventually break down and quit. Presently, we need you more than ever to help boost membership numbers and, in turn, make the medical profession stronger. One of the easiest ways to promote your profession is to recruit fellow physicians into the federation of medicine.

Direct mail solicitations sometimes gather new members. But nothing works better than physician-to-physician recruitment. You are your association's best salesperson. A physician is much more likely to help attract new members than any mailing. There is no reason why each MSMA member physician cannot recruit at least one non-member. One of the basic rules of association management is that a professional association is only as strong as its membership.

Do you realize that if each MSMA member persuaded just one new doctor to join MSMA, 86.72% of Missouri's physicians would be members? Imagine what the MSMA and your local society could accomplish for you and your practice with those kind of membership numbers. Of course, we can't just sit back and watch it happen. Missouri's physicians have to get the job done.

It may seem difficult with a full schedule to take ten minutes a week to recruit for your state and local medical societies, but it is also a necessity. Make it a personal challenge to see how many members you can recruit. To make it easy, there will be an application for membership in each issue of *Missouri Medicine*. The MSMA or your local society staff will be more than happy to provide you with legislative reports, brochures and other material.

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5. **If he or she is already a member, go back to step 2.**
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Perspective

All Physicians Should Pay Dues!

Charles Norland, MD
President-elect, St. Louis Metropolitan Medical Society

In August 1996, after a hard five-month battle, organized medicine (local medical societies, MSMA and AMA) successfully stopped the disastrous fraud and abuse provisions originally proposed in the Kennedy-Kassebaum Health Insurance Reform Act of 1995 (HR 3103) that would have led to unjust jailing and fines of innocent physicians for filing the wrong CPT code. The final compromise version of HR 3103 that was signed into law on August 21, 1996, strikes a delicate balance of affording government agencies the tools needed to catch fraudulent health care providers while ensuring that providers who make innocent mistakes or billing errors will not be punished.

Congress accepted two critical AMA provisions. First, only a physician who acts "knowingly and willfully" to defraud federal health care programs can be prosecuted for fraud offenses and second, civil money penalties can only be imposed if a physician acted "knowingly" and with either 1) "reckless disregard for" or 2) "deliberate indifference" to the "truth of statement" made in physicians' billing records.

Physicians say it is too expensive, and they are right – it is too expensive for 50% of physicians to pay dues when 100% of the physicians who have M.D. and D.O. after their name should be paying to protect and improve medical practice. If you want to bring the membership dues down, join with us today so we can all pay less.

In Missouri approximately half of the physicians paid dues to have AMA Executive Vice President P. John Seward, MD, spot the problem and contact Congress and the administration to express our concerns about the disastrous fraud and abuse provisions in the original Kennedy-Kassebaum legislation. Organized medicine carried out a major battle over five months with multiple encounters and thousands of letters coming from members of the local medical societies, MSMA, and the AMA. The doctors who are not part of organized medicine just sat in the doctors' lounge and whined, "ain't it awful." Let me be blunt – the doctors who are paying dues to protect medicine are getting fed up with the whiners who don't put their money where their mouth is. We want and expect every physician to pay dues and join with us in developing a good health delivery system for the future.

Physicians say it is too expensive, and they are right – it is too expensive for 50% of physicians to pay dues when 100% of the physicians who have M.D. and D.O. after their name should be paying to protect and improve medical practice. If you want to bring the membership dues down, join with us today so we can all pay less.

What has organized medicine done to save physicians money? Several years ago a bill before Congress would have put physicians starting out in practice on a percentage scale of Medicare reimbursement during their first four years of practice. This bill had a good chance of passing but was defeated by a rapid, full-court press by organized medicine. The defeat of this bill saved young physicians a 12.5% loss of

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reimbursement during their first four years of practice. Yet many of these young physicians won't pay to support organized medicine.

Physicians need to recognize that we are all under rigid wage and price controls, and the general public doesn't even know this. We are being dominated by for-profit insurance companies and the government. We have to do more than complain – we have to fight, and that means pay your dues.

In 1996 there was proposed legislation before Congress to decrease Medicare reimbursement to physicians by 2% a year for five years. Lonnie Bristow, MD, President of the AMA, went to Congress and explained that Medicare only pays 63 cents on the dollar now and that the overhead in doctors' offices across the country is 52 cents on the dollar. A 2% decrease would mean that almost all doctors would have to drop out of Medicare. Members of organized medicine paid dues to have Lonnie Bristow fight the battle. It would be good to have all physicians helping Lonnie Bristow to spot the problems and fight the battle for us.

I hear doctors say, in the past there were high salaries and multiple perks for the officers of organized medicine. In my opinion, there were some excesses in the past, but today, this is a lean, dedicated fighting machine. The salaries of the officers of organized medicine are in the same range as doctors who are in full-time private practice and academic medicine. All compensation is published and open to full scrutiny.

I hear doctors say, I am just a single voice; organized medicine is not democratic and does not represent me. I point out that every member of organized medicine can participate in policy making. If you pay your dues and join organized medicine today, you can introduce a resolution through a local or state medical society, specialty society, or AMA delegate. You state the problem with "whereas" statements; then "resolve" statements or solutions to the problem. If other physicians at the local and state level agree with you, it will then go on the AMA. A good, well written resolution can be national policy within six months. The system lets you complain but only if you have a good idea for a solution. This is democracy in action.

We have signed many contracts as individuals of small groups which we would never have accepted if we were organized. If we join together, we can help all physicians deal with contracts with gag clauses, withholds, and anti-ethical demands which are of concern to all physicians.

All dues-paying members are paying for the battle to protect medicine. Each individual can elect whether they do or do not want to participate in the meetings of organized medicine. Members are informed weekly about what is happening on the medical scene across the U.S. and the state with the excellent publications from organized medicine.

Some doctors say we should be a union and strike. We are a profession, and professionals do not have a history of striking. Physicians are in oversupply so the time to form a union is not good. Most doctors in private practice have multiple contracts with multiple insurance companies, so who would they strike against? We can't strike against our patients. No, we can't be a union.

The insurance companies know that physicians are not organized in business matters. In fact, they cannot believe that physicians have accepted all of their demands, gag clauses, and withholds. We have signed many contracts as individuals of small groups which we would never have accepted if we were organized. If we join together, we can help all physicians deal with contracts with gag clauses, withholds, and anti-ethical demands which are of concern to all physicians.

Organized medicine includes local medical societies, the AMA, and the Missouri State Medical Association. All three have a vital role so there should be no picking and choosing. Most of the health insurance legislation and patient protection that impacts our lives is done at the state level. The MSMA has written and sponsored two major bills – the Health Insurance Reform Act and the Patient Fairness Act – in Jefferson City during the last two sessions. The timing will be right for these bills to pass this year. We need a lot of physicians in Jefferson City over the next year. The MSMA lets us know when we are being attacked at the state level, and they fight for our rights and the rights of all citizens in the state of Missouri. In February 1994 there was an attempt by the state executive and legislative bodies to take away the practice of medicine from doctors with HB 1622. A full-court press by MSMA and the local medical societies defeated this bill.

Physician membership is up in the subspecialty and specialty societies over the last 10 years because they are our major source of postgraduate education. These organizations, however, speak with multiple, conflicting voices. Subspecialty societies cannot effectively deal with these issues. If they are honest, they will admit they don't have significant political clout. The AMA is bringing the subspecialty societies together with the "Federation Plan."

We need all physicians in Missouri, but most importantly, we need the faculties of our great medical schools. In medical school, we start with stars in our eyes, and our teachers lead the way. The medical school faculty has to teach medical students the importance of developing and maintaining a good health care delivery system. Medicine is threatened by many people who want a piece of the $1 trillion action. But let's set the record straight. All that is needed to deliver good medical care is a physician, a patient, an office, a pharmacy, and a hospital; everything else is the tail. The for-profit insurance companies are the tail and they are wagging the dog. They don't care about medical research, care of the indigent or the chronically ill. They don't care about medical education or medical ethics. The vast majority of physicians know that all of the goals of the medical schools are vitally important. Organized medicine will fight for the goals of the medical schools, but we need the medical school faculties to join us in the fight for our profession.

The MSMA has written and sponsored two major bills – the *Health Insurance Reform Act* and the *Patient Fairness Act* – in Jefferson City during the last two sessions. The timing will be right for these bills to pass this year. We need a lot of physicians in Jefferson City over the next year.

Overall, membership in organized medicine is down, particularly among young doctors. These young doctors are, however, bright spots in membership in California and Minnesota where the membership is way up. Physicians in these states have been hammered by insurance companies for years. Before we get hammered, let's join together by having everybody with M.D. or D.O. after their name become a member of organized medicine. We need your support at all levels. Applications for membership in your local medical society, MSMA, and the AMA are readily available.

We must have the major voice in the restructuring of the health care delivery system. This is our life's work. To carry on the battle, organized medicine has considered raising dues, but all we need is for everyone to pay their dues. It is obvious that organized medicine is fighting for vital issues important to the vast majority of physicians. To win we need the majority of physicians to pay dues and be a member of organized medicine – don't bump light!

Now what should members do? All members - feel free to make multiple copies of this article and recruit your nonmember colleagues. Will nonmembers join us? They will join but we have to make it happen. We all have the same goals and aspirations. If we don't fight, the profession will be diminished. The applications to medical schools continue at an all time high because the youth of America know that what we do is important. We didn't go into medicine with diminution in mind. Let's all fight the battle! MoMed

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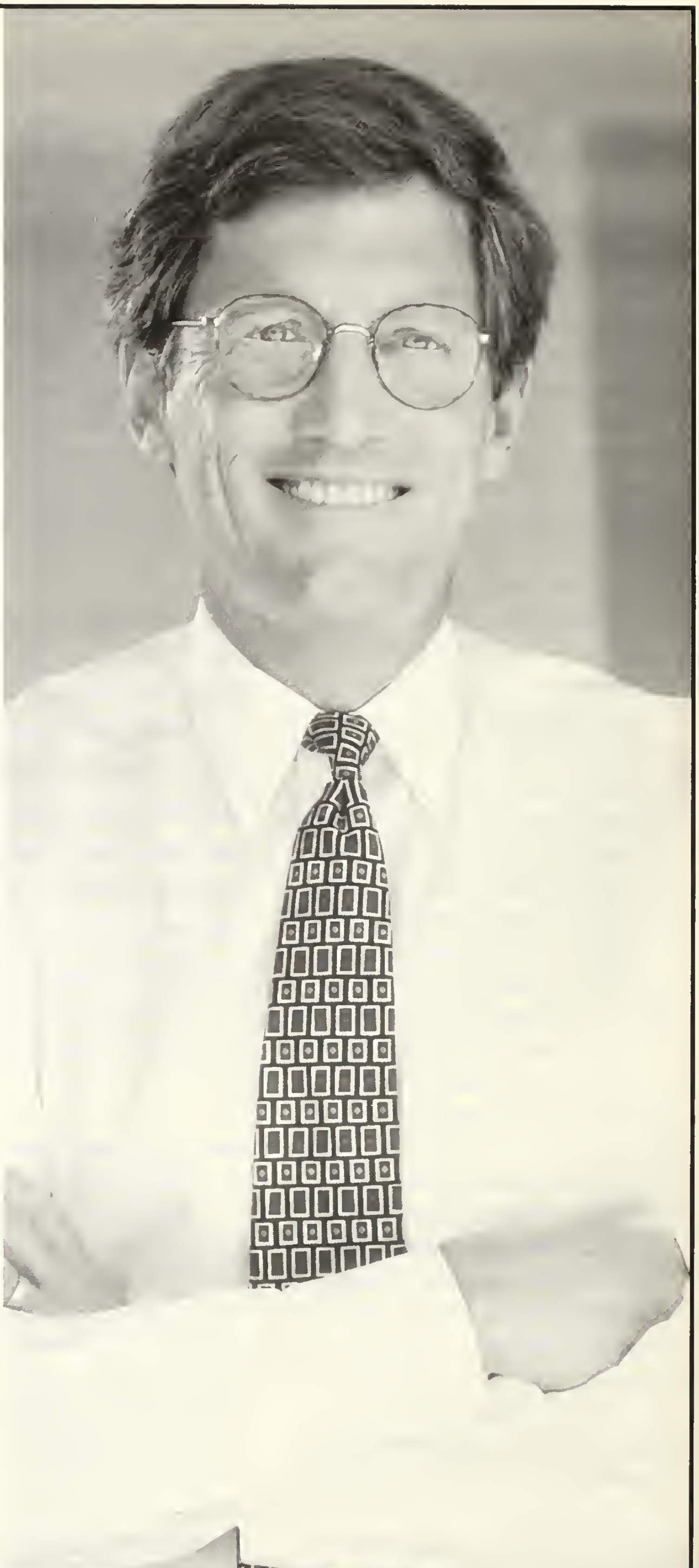

The Other Problem With Physician/Employees

A Closer Look at Rural Hospital/Physician Relationships

Charles A. James, PhD and Michael S. Nichols, PhD

Problems are inevitable when hospitals and physicians pursue their individual interests under the framework of a poorly conceived relationship, i.e. one in which the stakeholders do not share risk and return equitably. This article documents three cases where this "equal-stakeholder" approach did not exist and how the unfortunate results could have been avoided.

The growth of community hospitals acquiring surrounding physician practices during the past ten years has been well-documented. The reason for this phenomenon is not mysterious. In the face of constant change and uncertainty, hospitals want to preserve their referral base. The acquisition of clinics supplying this referral base is a common approach for achieving this goal. Competition between hospitals in a given region adds a sense of urgency to this strategy. The volume of these recent purchases has exposed some serious shortcomings in this type of hospital/physician relationship. Unfortunately, the following scenario is still too common. Hoping to secure its referral base in an increasingly competitive marketplace, a hospital pays generously for a thriving practice and employs the physician without specifying performance requirements. The hospital is then perplexed when the doctor who formerly had a large practice as an independent practitioner is now seeing significantly fewer patients as a physician/employee. A standard explanation given by the physician/employee is an "unwillingness to compromise standards of quality" due to a large volume of patients. In this scenario, the hospital first failed to recognize the tendency of people to act in their own best interest and second, structured a relationship in which the stakeholders in the practice did not share equitably in the risk and rewards of the practice. Obviously, building performance requirements into the employment contract attempts to overcome this inconsistency. It is difficult to do so, however, without sacrificing some amount of goodwill that may have existed when the physician was first approached. Physicians in general find performance requirements objectionable from a professional point of view.

Reduced productivity on the part of the physician/employee, however, is only one way in which poorly structured relationships are exploited. Hospitals in pursuit of their own "perceived" best interest, can end up alienating or taking advantage of the medical staff. In light of these shortcomings, both hospitals and physicians are groping for appropriate hospital/physician relationships that will not only protect their individual interests but create synergy and security in a volatile and ever-changing environment. It is the experience of the authors that while the movement in rural areas to hospital-employed physicians seems to serve the interests of both parties, it is in fact an unstable foundation on which to build the future of health care. This is because the risks and rewards of the practice are often not shared equitably by all shareholders. Moreover, any relationship in which the parties have an inequitable stake in the risk and return of the practice, or in which one physician is given more support from the hospital than another, is a prescription for conflict.

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The solution to this dilemma is to structure the relationship so that both parties are allowed to act in their own best interest while simultaneously supporting the other party's objectives. This structure is not the traditional employer/employee arrangement but one in which **the benefits and risks of the practice are shared equitably by all stakeholders**. We refer to this structure as an "equal-stakeholder" relationship. The need for an equal-stakeholder relationship is best illustrated by relating some cases which demonstrate the type of problems that result from the pursuit of individual interests under the framework of a poorly conceived relationship, i.e. one in which the stakeholders risks and rewards are out of balance.

Case 1: Physician Exploitation of Employment Agreement

Sometimes it is a physician's ambition rather than a lack of productivity that becomes problematic. This case describes how two very productive, and ambitious physicians took advantage of their employment agreement with the hospital.

A small community hospital owned two clinics staffed by a husband and wife physician team. In order to attract them to the community, it was necessary to pay them each $180,000, plus a productivity bonus. The compensation package was clearly influenced by competition from another hospital approximately 35 miles away which was also actively recruiting the physician team. In an effort to ensure that the physicians covered their expenses, their contract specified that each physician was required to work in the two, hospital-owned clinics a certain number of hours each day. The contract did not specify any restrictions on their professional activity while not working in the clinics.

Subsequent to signing the employment contract the physicians opened a third, privately-owned clinic. As soon as their hourly contractual obligations with the hospital were met, the physicians redirected patients to their private clinic. Obviously, these physicians were violating the spirit of their contract. While the hospital experienced increased referrals and inpatient revenues, the losses incurred at the clinic level more than offset any desired benefit to the hospital's overall financial position. Specifically, the hospital inpatient revenues have increased $5 million per year. Assuming the hospital realizes a 10% net margin (which is unlikely), the margin on the $5 million would generate $500,000 net revenue. However, the hospital is currently losing $600,000 per year on the hospital-owned clinics.

The problem presented in Case 1 could have been avoided if the terms of the contract had been more specific and had been designed to optimize benefits for hospital and physicians alike. The relationship needed to be structured so that it was financially optimal for the physicians to continue working in the hospital-owned clinics, rather than redirecting patients to the privately-owned clinic. Clearly the stakeholders interest in the hospital-owned clinics was out of balance.

Case 2: Independent Physician Forced Out of Practice By Hospital

This case involves a hospital that through poor relationship management caused a local, independent physician to close his practice and leave town. Ultimately, the physician, the community, and the hospital lost.

A local, independent physician had been practicing and providing the community hospital with referrals for sixteen years. He had a healthy practice and was well-liked in the community. Concerned about preserving its referral base, the local, eighty-bed hospital approached the physician with a proposal to purchase his practice. He gave the proposal serious consideration but decided to continue practicing independently as he always had.

Sometime later the hospital received a grant to develop an "integrated network." This network was to be comprised of the hospital, a nursing home, home health agency, and local physicians. With a portion of the grant funds, the hospital hired a new physician/employee for $200,000 per year. The new physician/employee alternated his time between the office and the hospital emergency room. While this arrangement did not seem threatening at first, it was clearly in the hospital's best interest to refer all of its ER follow-up visits and nursing home patients to its new physician/employee. In this way the new physician/employee's patient base would grow from the hospital-generated referrals. There was pressure to grow the physician/employee's practice quickly to cover the $200,000 salary before the grant money was depleted. Certainly the new physician/employee wanted to make a good impression by quickly growing a thriving practice and had no qualms about absorbing patients from other physicians. In most cases, if patients were told to go to a particular physician for follow-up they did so, and many times continued to see the new physician/employee rather than going back to their original physician. The independent physician was powerless to prevent the continuing erosion of his patient base and eventually became so disillusioned by the hospital's disregard for his concerns and eventually lost so much of his patient base that he closed his practice. There is no guarantee that the new physician/employee will ever generate enough revenue to cover his grant-subsidized salary, benefits and practice overhead. So the hospital lost a productive, self-supporting, independent physician and gained a physician/employee that may have to be released at the end of the grant period leaving the community without a physician.

In this case each party acted in their own "perceived" best interest, but because the hospital's interest in the two practices was not equal the result was devastating. Had the relationship been structured such that the hospital did not have such a vested interest in one physician over another, the problem would not have occurred. The hospital should have an equal stake in the practices that support it or someone will suffer the consequences.

CASE 3: Hospital Wants The Rewards Without the Risk

Sometimes hospitals, understanding the potential pitfalls of employing physicians, make it their policy not to buy physician practices, but still become involved in relationship problems when risks and rewards are not shared equitably.

A community hospital took the position that they would support the physicians on staff but would not attempt to buy their practices. One of the more prominent physicians in the community decided, after nine years of developing his practice, that the time was right to hire a second physician and pursue certification in the Rural Health Program.

With the assistance of the hospital, the physician identified and hired a second physician as an employee of the practice. His employment contract specified $115,000 per year but neglected to specify any performance requirements. The hospital was in support of this effort and agreed to subsidize a portion of the new doctor's salary. This subsidy was in the form of a demand loan to the practice, one-fourth of which was forgivable after each of four consecutive years of service by the new physician.

The physician also hired a mid-level practitioner to fulfill the requirements of the Rural Health Program. Unfortunately, shortly after his application was forwarded to the appropriate state agency, inspections by the state were suspended indefinitely due to the budget battle that was taking place in Washington. Because inspections were suspended, and the practice was relying on increased revenues from participation in the Rural Health Program to compensate for the newly incurred expenses, the practice began incurring a substantial amount of debt. While certification and its higher, cost-based reimbursement rates would have lessened the financial burden of the new providers, it also would have masked the real problem; namely, the new physician was not building his own practice and therefore was not generating sufficient revenue to cover his salary and the concurrent overhead.

Various alternatives were explored and several measures were implemented to increase the new physician's patient base and improve the financial viability of the practice, including opening a second office in a neighboring town. After several months of operation, it became clear that the new physician did not know how to build a practice and his contract offered no incentive to learn. Productivity analysis verified that he was causing the practice to lose approximately $7,000 a month with no hope for improvement. Ultimately, the physician/employee received a letter terminating his employment.

It was in the hospital's best interest for the new physician to remain on staff; however, the hospital had not assumed any of the financial risk. It was the physician who employed and paid the new physician/employee. The hospital's salary subsidy was in the form of a loan to the practice (not the employee) that was payable on demand. The hospital enjoyed much of the benefit (in the

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form of referrals) but none of the risk. When it was announced that the physician/employee was terminated, rather than supporting the staff member of nine years who had incurred thousands of dollars of debt, the hospital sided with the physician/employee who had not completed even one full year of service. The hospital was adamant that the practice either continue to employ this new physician/employee; or subsequent to termination, surrender to him at no cost, ownership of the second office, so he would have a place to practice. In light of the seemingly strong support of the hospital to retain the second physician, it was proposed that they employ him. There was little interest in that proposal.

This scenario demonstrates the pitfalls of an inequitable relationship. To be equitable, risk and reward must be shared. In this case, the physician/employee had a guaranteed salary and no incentive to increase production. The hospital added another physician to its staff with essentially no financial risk. The only one who had any risk was the physician/employer and because of his employee's poor performance there was no reward. An equal-stakeholder relationship should have been established for all three interested parties.

Solution: The Equal-Stakeholder Relationship

In each of these cases, the individual parties acted in their own self-interest. In Case 1, two physicians took advantage of their employment contracts to create competition for the hospital-owned clinics where they were employed. In Case 2, a hospital lost one of its most productive, independent physicians in an effort to increase its referral base by hiring a new physician/employee. In Case 3, the hospital was unwilling to accept the risk of hiring a physician/employee but had no apprehension against treating a veteran member of the medical staff unfairly for the benefit of a new, relatively unproductive physician. Each of these situations occurred because the hospital/physician relationship did not create the right incentives.

While finding the right, equal-stakeholder relationship between hospitals and physicians may not solve all problems, it can go a long way toward creating a harmonious environment in which each party can pursue their own interests without adversely affecting the other parties.

The goals of hospitals and physicians are often different. Just because they are different, however, does not mean they are mutually exclusive. The solution to ensuring that these goals are mutually **beneficial** lies in striking the appropriate balance between employment and participation. Individual circumstances may place the interests of the physician at odds with those of the hospital. The fact that these two entities are enormously dependent upon each other is all too often forgotten. The practice of good medicine will not be achieved without a good hospital and a well-rounded medical staff. The physician and the hospital will both benefit by implementing a plan to ensure the solidarity of their relationship.

The equal-shareholder relationship should foster loyalty, not buy or dictate it. It also needs to provide incentives to the provider to be productive. Inclusion must be the guiding principle to avoiding adversarial relations. Agreements between the hospital and physician should not benefit one party at the expense of the other. It is the failure to recognize opportunities for mutual benefit and extinguishing threats in the interest of self-preservation that is the beginning of the end for many hospital/physician relationships.

These arrangements must be financially feasible as well as a mechanism to share risk and rewards. The first priority in the delivery of medicine is to ensure that patients receive quality care. This can only be achieved in a practice whose financial health allows for independent performance. If not deftly handled, performance requirements tend to offend the physician by dictating how medicine will be practiced. The quality of care argument lends substantial weight in opposition to these parameters. It is reasonable to assume that the physician will take on some level of risk if the potential rewards are enticing enough.

The relationship that best meets the above requirement is one in which the risks and rewards are shared equitably, the "equal-stakeholder" relationship. This arrangement does not dictate that ownership of the clinic be a 50/50 partnership; only that the balance of risk and reward are structured equitably for all

Table 1. Alternative Outcomes for Rural Hospital/Physician Relationships

	Hospital	Physician
1.	Buys practices to secure referral base.	Wants to maintain independence.
2.	Wants performance standards in employment contracts.	Wants self-imposed production levels.
3.	Wants to pay as little as possible for practice and physician.	Wants to get as much as possible for practice and in compensation.
4.	Wants to increase referrals from physician.	Wants autonomy in medical decision-making.
5.	Gives a physician/employee preferential treatment.	Believes hospital should treat all physicians equally.
6.	Wants to add quality physicians to staff.	Wants to limit the number of physicians and competition.

Goal Compatibility Under Equal-Stakeholder Relationship (Assumes 50/50 Shared-Equity with all Physicians)	
	1. Each party owns half the clinic so referral base is secured and physician is not subordinate. 2. Physician share residual income so there is no need for performance standards. 3. Hospital only buys half the clinic which reduces cost. Neither party is as inclined to take advantage of future partner. 4. Both parties have an interest in the success of the other. 5. Since hospital owns equal stake in all clinics and wants all to succeed, there is no incentive to favor one over the other. 6. Equal stakeholder relationship leads hospital to protect all its medical staff from inappropriate competition.

stakeholders. One example of an equal-stakeholder relationship is a shared-equity arrangement. Under this arrangement, the hospital and the physician are equal shareholders in the stock and ultimately the risk and return of the practice. Other benefits can be negotiated depending upon the desires and the financial position of the parties involved. In a shared-equity relationship the physician is provided with job security as an owner of the clinic with the opportunity to share in the profits should productivity thresholds be achieved. Adequate autonomy in practice management can be maintained for the physician with the added benefit of the hospital's support should unforeseen problems arise. The hospital is rewarded with a loyal physician because the physician is a partner instead of a subordinate. The initial outlay on the part of the hospital for the practice is less in this scenario, and the physician's compensation is still tied to productivity.

The Table above summarizes some of the potential goal conflicts between hospitals and physicians, and how those conflicts might be avoided under an equal-stakeholder relationship.

The details of this kind of relationship are subject to individual circumstances, but it is a logical framework that does not ignore the tendencies that are basic to human nature. It avoids the pitfalls that are easily found when self-interests collide. With the support of the hospital, the physician achieves some insulation from the forces of consolidation and can maintain individuality that has been the traditional backbone of medical care in this country. The hospital achieves the same insulation in the continual solidification of its referral base, thus guaranteeing its financial well-being. Financial well-being for both hospitals and physicians will help these parties concentrate on the foremost objective...the health of our citizens. MoMed

The Authors

Charles A. James, Sr. is a professor of finance, and **Michael S. Nichols** is an adjunct professor of finance at St. Louis University School of Business. Both are consultants with North American Rural Health Services, Inc.

MSMA is looking for specific problems physicians may be having with MC+

Missouri Medicaid asked MSMA to assist in gathering examples of administrative hassles that physician offices are having, especially in the areas of authorization and claims. It has been reported that some offices have received claim denials by an MC+ HMO for previously-authorized treatment. Others have described claim payments to be as slow as the previous Medicaid plan, and that staff routinely waits on the phone to receive authorizations. MSMA was told that Medicaid will be reviewing HMO operations, but requests that physicians provide specific, documented examples of administrative difficulties. **Please mail your experiences along with copies of documentation to Pat Mills, MSMA Director of Health Care Finance, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.**

Wanted:

Creative Physicians to submit articles, editorials, photographs, artwork, etc. to your medical journal, Missouri Medicine.

YOU to be published.

Advisory Group Is Not Satisfied With The MC+ Patient Satisfaction Survey

Frederick Peterson, MD, MSMA Representative to the Medicaid Statewide Quality Assessment and Improvement (QA&I) Advisory Group

Since April of this year the Medicaid Statewide Quality Assessment and Improvement (QA&I) Advisory Group has been meeting on a bimonthly basis. The purpose of this group is to advise the Department of Social Services on the success of the Missouri Medicaid Managed Care program and to develop and critique the "Quality Indicators" that have been designed to measure outcomes.

While many of the indicators are still under development, two indicators have been determined – Immunization Performance and Compliance and the Patient Satisfaction Survey.

The Patient Satisfaction Survey is being circulated to Medicaid patients. This survey, which is actually a three-page document, is provided in a condensed format on the next two pages. It is one of three versions presented to the advisory group. At the time of presentation, many of us questioned the survey's length and level of reading difficulty. It is written for a reader with at least a seventh (7th) grade education, which is at variance with the education level of most Medicaid recipients. The suggestions of the advisory group were not acknowledged.

The Patient Satisfaction Survey is being sent on a random basis to 200 families who are participating in each the MC+ plans. Depending on the response rate, a second mailing will be sent in order to get an adequate sampling size.

A survey assessing provider satisfaction was also presented to the advisory group. The group rejected the Provider Satisfaction Survey. It being revised and will be presented to the group for critique in the near future.

As plans begin reporting data in a uniform manner, for which protocols have only been released recently by Medicaid, the development of additional quality indicators will be possible. MoMed

DRAFT VERSION B DRAFT

affix label here
MEMBER NAME & ID NUMBER

MC+ MEMBER SATISFACTION SURVEY
EASTERN REGION

Missouri Medicaid is conducting a random survey of MC+ members to measure the quality of services provided by MC+ health plans. The individual listed above has been selected to take part in this survey. If the individual listed above is a child, a parent or guardian should complete the survey for them. All the responses will be kept confidential. When the survey is completed, Missouri Medicaid will make a report on the health plans available to all MC+ members. This report will help you choose a plan for yourself and your children based on the things you feel are important. Please take a few minutes to fill out the survey and mail it back. If you have any questions, please call XXX-XXX-XXXX. Please print your answers. Thank you for your help!

2. Thinking about your own health care and the services you receive from your MC+ health plan, how would you rate the following?

	Poor	Fair	Good	Very Good	Excellent
a. Ease of making appointments for medical care by phone					
b. Length of time you wait between making an appointment for routine care and the day of your visit					
c. Thoroughness of treatment					
d. Attention given to what you have to say					
e. Number of doctors you have to choose from					
f. Ease of choosing a personal physician					
g. Amount of time you have with doctors and staff during a visit					
h. The outcomes of your medical care, how much you are helped					
i. How well your care meets your needs					
j. How well the whole system works together to coordinate your medical care, including how well different people and departments communicate with you and with each other about your care					
k. Overall quality of care and services					

3. Have any of the following been a problem for you in arranging for your medical care? If so, how much of a problem?

	Yes, big problem	Yes, a small problem	No, not a problem
a. Delays in your medical care while you wait for approval by your health plan			
b. Difficulty in receiving care you and your doctor believe is necessary			
c. Not being able to get a referral to a specialist you want to see			

4. How long do you usually have to wait between the time you make an appointment for care and the day you actually see the provider?

	day	1-3 days	4-7 days	8-14 days	15-30 days	31-60 days	61+ days
a. Routine Care (like a check-up)							
b. Minor illness or injury (like treatment for a sore throat)							
c. Chronic or ongoing condition							
d. Urgent care							

Continued on next page

5. When calling for medical information or advice, how long does it usually take for your provider's office to return your call?
   ☐ Less than 1 hour ☐ 1 hour, but less than 4 hours ☐ 4 hours, but
   ☐ less than 7 hours ☐ 7 hours, but less than 24 hours ☐ 24 hours or more

6. Once you get your provider's office, how long do you usually have to wait to see your provider when you have an appointment for care?
   ☐ Less than 10 minutes ☐ 10-15 minutes ☐ 16-30 minutes ☐ 30-45 minutes
   ☐ 45 minutes - 1 hour ☐ 1-2 hours ☐ 2 hours or more

7. When you go for medical care, how often do you see the same provider?
   ☐ Always ☐ Sometimes
   ☐ Most of the time ☐ Rarely or never

8. Have you called or written your MC+ health plan with a complaint or problem in the last 12 months?
   ☐ Yes - please answer question 9. ☐ No - go to question 10.

9. How long did it take for the health plan to resolve your complaint?
   ☐ Same day ☐ 1 week ☐ 2 weeks
   ☐ 3 weeks ☐ 4 or more weeks ☐ Not yet resolved

10. All things considered, how satisfied are you with your current health plan?
   ☐ Completely satisfied, couldn't be better ☐ Neither satisfied, nor dissatisfied
   ☐ Very Satisfied ☐ Somewhat dissatisfied
   ☐ Somewhat Satisfied ☐ Completely dissatisfied, couldn't be worse

11. During the past 12 months, did your plan's overall performance get better, stay the same, or get worse?
   ☐ Much better ☐ Somewhat better ☐ Stayed the same
   ☐ Somewhat worse ☐ Much worse

12. Would you recommend your current health plan to your family or friends if they needed care?
   ☐ Definitely yes ☐ Probably yes ☐ Probably no ☐ Definitely no

13. Do you intend to switch to a different health plan when you next have an opportunity?
   ☐ Definitely yes ☐ Probably yes ☐ Probably no ☐ Definitely no

14. Would you say that in general your health is:
   ☐ Excellent ☐ Very Good ☐ Good
   ☐ Fair ☐ Poor ☐ Don't know/not sure

15. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? ________________

16. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
   ____

17. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation? ________________________

Comments: ____
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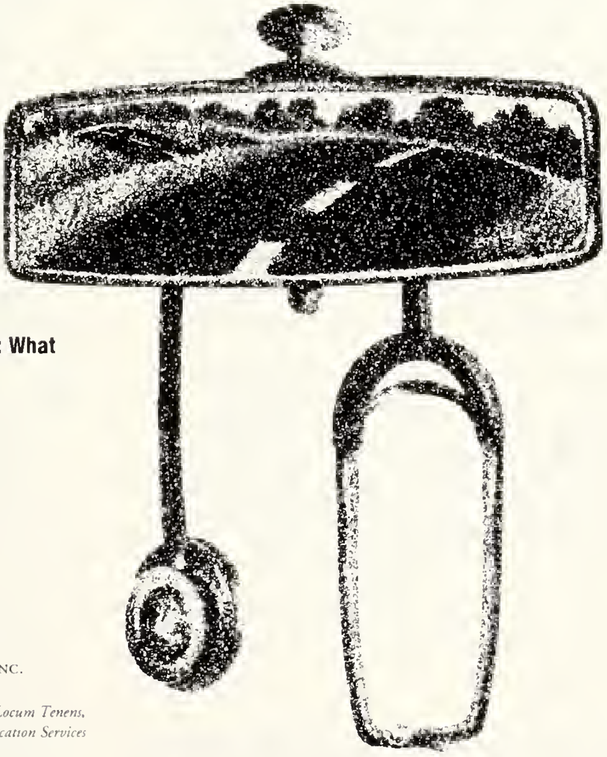

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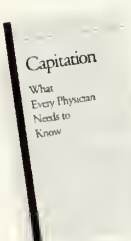

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"CASH IS KING"

Gary M. White, CPA, MBA

In this time of increasing managed care and continued reductions in payments for services provided, many physician practices feel helpless as to our ability to have any significant impact on the profitability of our practices. This should not be so! There are a number of activities with our practices which we should review to insure we are optimizing the cash receipts to us. After all, the basic premise of all small businesses, including medical practices is cash flow is our lifeblood, "CASH IS KING."

Improving our flow of cash into our practices is not merely the receipt of insurance payments, but the logical culmination of several interrelated steps in the patient process which maximize the potential cash flow rightfully due the practice. A step by step outline of the major categories in the process follows:

1. The practice continues to retain some ability to generate additional cash flow by increasing rates. A complete discussion of this topic is in the June 1996 issue of *Missouri Medicine*, "Using Relative Value Units (RVUs) to Develop Your Pricing Schedule" by myself and Tom Bennett.

2. When the patient is scheduling the appointment, or at the time of the visit, obtain complete insurance information including deductibles, copays, precertification requirements, etc. Make copies of insurance cards whenever possible. Upon subsequent visits, update insurance coverages.

3. Collect all deductibles and copays at time of service to speed up cash flow and reduce follow-up billing efforts.

4. Attempt to bill all insurance claims electronically to reduce insurance company processing time. Electronic processing requires you to completely and accurately complete all required fields, and minimizes rejected claims which have to be re-filed.

5. Be knowledgeable of your procedure and E & M codes. Use current CPT coding books and understand them. Discuss them and question your physicians on any areas which are unclear. Ask your physicians to share material on coding or billing from their professional societies. Attend a coding or billing seminar annually to maintain expertise. Accurate and complete coding (especially multiple ICD-9 codes) supported by complete medical records maximizes your reimbursement and gives the various carriers the necessary data to properly compare you with your peers from their payment data bases.

6. Periodically audit billing to the medical record and discuss any differences. Look at "normal" distribution curves by physician for levels of office visit to determine if there are any significant variances by physician in your practice. Review charts to understand the basis for any variances.

7. Consider billing secondary insurances for your patients and collect estimated non-covered portions up front. Adjustments, if any, may be refunded after all insurance has been paid.

8. You should be loading into your computer system all insurance company contract allowables (including Medicare) at the time of the initial agreement and with annual updates to the fee schedules. Compare your Explanation of Benefits (EOB) to each fee schedule and follow-up in writing with the carrier on any differences, requesting the additional fees due you.

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9. After insurance is billed, initiate follow-up after 20-30 days and each week thereafter as to expected payment dates. This is one of the most important steps in the cash flow process as many practices bill insurance then go on to other business activities and assume the claim will be paid. By focusing on this one step alone, a practice may reduce the outstanding accounts receivable by 10-15%.

10. On Medicare disputed or disallowed payments, request review in writing using supporting data such as physician narrative, operative reports or other appropriate documentation.

11. Develop hospital coding cards or forms for the physicians to accurately and completely "check off" the work performed in the hospital. Compare the coding sheets with the procedure dictation to insure all work is included and coded correctly.

12. Develop a written practice collection policy insuring the physicians and staff clearly understand and follow it. Also, develop guidelines on how the practice deals with self pay or "no insurance" patients as to deposit requirements, monthly payments, interest charged, if any, and payment time frames. Consider using credit cards, or make available bank loans in lieu of extended payment plans as your practice is in the business of delivering medical care, not in the banking or finance business.

13. Make sure your practice is "Patient Friendly." Review your systems, procedures and staff as to courtesy, accessibility and ease of access to your practice. Consider some of the types of marketing concepts such as those covered in the *Medical Marketer's Guide, 2nd edition* by MGMA, or other similar publications. Also, you are aware the managed care plans review providers in terms of patient satisfaction. Make your patients feel welcome. Practice growth equates to increased cash flow without a significant increase in overhead expenses and your existing patients can be a significant source of new patients.

14. Another component of improving cash flow is increased volume or market share via increasing managed care plan contracting. Most practices have the ability to handle 10-20% additional patient volume without significant increase in overhead costs. Therefore it may be beneficial to look at joining additional plans to increase the volume, assuming contract terms are satisfactory.

15. Look at the range and type of services your practice offers and the payments you receive from each area. Are there services on which you lose money? Are they necessary to your practice? Are there services which are profitable which you might add?

This article shares some ideas you might consider which improves cash flow from the patient registration, billing and collection areas. Cash flow can also be improved by looking carefully at the various practice overhead expenses. This will be the topic of a future article. MoMed

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Health Care Development as an Emerging Industry, Part I

Timothy McIntire, MD, MBA

Health care is a sea of change these days, and we as physicians often have a hard time dealing with the pace of change and change itself. While we may feel that this change is a recent phenomenon, history tells us that health care delivery throughout the 20th Century has been one of rapid expansion and change. In thinking of health care as the multi-billion dollar industry that it has become, we will address the economic and strategic emergence of the health care industry in this article, and the maturation of the industry in a subsequent article.

One may think of health care in the 20th Century as having evolved through four stages of change since the post World War II era. The first stage is described by the proliferation of individual hospitals and physicians which was begun by the Hill-Burton programs, funding hospital construction and growing medical schools and medical education. The second stage began in the late 1960s and early 1970s with the emergence of the investor owned and not-for-profit multi-hospital systems. The primary focus of these systems was on achieving economies of scale, developing a stronger capital base, and solidifying market share across wider geographic areas. In the late 1980s to the present, a third stage of multi-hospital systems and other integrated health care groups has emerged in an attempt to become integrated delivery systems.

As managed care grows, multi-hospital systems often need to organize and manage the entire continuum of health care, from the primary care of the patient to hospice care. As the delivery of health care has moved from hospitals to integrated systems, the number of physician groups and large multi-specialty clinics has grown. The natural progression of these three stages is to build the foundation for the fourth stage of development which will involve more community health care management. Medicine, management and public health will likely be united in this latter stage.

Over the past ten years, Missouri's urban areas have witnessed a transformation into managed care which has forced a formerly fragmented health care industry into the atmosphere of an emerging, rapidly consolidating industry. Rural areas of the state are now beginning to see and feel some of these changes. In an effort to better understand and manage these changes, the following discussion will describe some of the characteristics of emerging industries in general, many of which have a direct bearing on health care.

Emerging industries are newly formed or reformed industries that have been created by technological innovations, shifts in relative cost relationships, emergence of new consumer needs, or other economic and sociological changes that elevate a new product or service to the level of a potentially viable business opportunity. The health care industry transformed in the 1980s with the emergence and penetration of managed care in the urban areas of our state. To better understand the drivers of this radical change, one may look to several areas.

Although many markets can differ in their demographic characteristics and provider distribution, there are some common structural factors which may describe similarities in the evolution and maturation of these markets.

Technological Uncertainty

There is a great deal of uncertainty about the technology in an emerging industry. Breakthroughs in medical technology, clinical research, pharmaceutical products, surgical techniques and information systems continue to define and redefine the standard of care our patients receive. Rapid development and deployment of these breakthroughs will continue to press the health care delivery system as it balances the expense of delivering care with the cost of that care to private industry and the government.

Strategic Uncertainty

There is no clearly identified way to approach managed care. Markets differ in their composition and demands, and health care is often a local decision made by local industry. Senior citizens mostly look close to home for their health needs. Physicians, hospitals, other health care providers and HMOs are consistently assessing their patient's and market's needs. One must be aware of national and regional trends as they relate to the changing environment, then use and translate that information into a local strategy as it relates to product differentiation, market positioning, strategic planning, technological acquisition and patient care.

Steep Cost Reductions

There is often a steep learning curve as an industry matures from the fragmentation of providers and begins to consolidate into integrated delivery systems. Technological breakthroughs lead to operational breakthroughs which drive efficiencies in the delivery of patient care. As the excess capacity we have in hospital beds and services decreases, cost reductions will be found. These cost reductions will balance many of the increases seen in the cost of health care delivery. Physicians must lead their local medical staffs in implementing reasonable changes to more efficiently treat patients on both an inpatient and an outpatient basis. Physicians must also consolidate to better serve their patients in these new delivery systems. Physician communication with hospital systems and HMOs will prove to be the most valuable link in the implementation of cost containment and the evolution of health care into the next century. Physicians who are able to communicate appropriate cost reduction strategies and manage the efficient use of technologies for the betterment of patient care will balance much of the uncertainty before us as the health care industry matures.

Embryonic Companies

The emerging phase of any industry is usually accompanied by the presence of many newly formed companies with explosive growth potential. In health care we have seen the emergence and growth of home care agencies, pharmacy benefit and disease management companies, biotechnology companies, physician practice management companies, health law firms, health care consulting agencies, MSOs, PHOs, hospital system mergers, and integrated health care delivery systems. Many of these new companies and organizations have aided in the maturation of efficient health care delivery. Physician input and leadership in the development and management of these companies will prove to be pivotal. As the health care dollars transfer from inpatient care to outpatient and home care, patients will expect the same high quality from providers. Physicians must help imprint these growing economic companies into the mind-set of value in patient care, thus balancing their technological growth with individual patient care. These companies must harness their growth and potential to serve as the new frontier of medical care, offering insights to new and better medical practices and allowing for the measurement and management of long-term patient outcomes. Planning and implementing provider sponsored programs to fulfill these evolving needs will allow the successful maturation of many delivery systems.

Absence of Infrastructure

The maturing physician and health delivery systems will need strong foundations to support the changes managed care brings. Integrated, seamless, total health care, supported by information systems which collect and supply information for providers to make decisions, will be the backbone of the future of health care delivery.

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Information systems are moving from the current process of simple automation to the centerpiece of health care integration. The full benefits of integrated information systems will not be realized until independent systems can share medical information, including outcomes and resource consumption data, to determine best practices. Current barriers to integrated information systems, including high costs security of patient information, and lack of standardization of data, must be lowered.

As the health care industry matures, physicians must lead the process of improving the magnitude of information required to be collected, securing the investment in both financial and human resources, solving confidentiality and privacy issues, bridging the unwillingness of organizations to share data, and forging consensus on data to be collected and formats to be used. Only when these issues have been addressed will the foundation for the information age of health care delivery be cemented.

Erratic Product Quality and Cost

As much as we physicians do not want to admit it, the quality and outcome indicators we use in comparing health care delivery are quite immature. Health services researchers have long been aware of variations in the practice of medical care among communities and regions. In the 1970s studies among local hospital market areas in Vermont and Maine revealed wide variations in the per capita numbers of hospital beds, employees and physicians, and noted the direct associations between the supply of resources and the use of care. (*The Dartmouth Atlas of Health Care*) The more beds a community had, the greater the rates of hospitalization, and the more surgeons a community had, the higher the surgical rates. In the 1980s a series of studies in Boston and New Haven, Connecticut extended insights into this variation phenomenon, again duplicating the findings of the Vermont - Maine study. This most recent study demonstrated that the care one receives depends largely on the supply of resources available in the place where one lives.

Geographic variation studies also highlight evidence that populations in low-cost regions are not sicker or in greater medical need than those in high-cost regions. Costs are higher because the local health care systems have greater capacity or because the price of comparable medical care per unit is higher.

As information systems mature and give physicians the data needed to better address cost and quality variations among communities, physicians must use this information to convince their peers to take note of the variations, and manage the differences to better, more efficiently treat their patients.

In conclusion, the formulation of a strategy in an emerging industry must address the uncertainty and risk of this early period in the industry's development. The rules of the competitive game are largely undefined, the structure of the industry is unsettled and often changing, and the competition is hard to identify. Physicians must learn to manage the perceived chaos within this emerging industry. By focusing on long-term, value-based decisions, collaborative efforts among all types of health care personnel, and information empowered behavior, physicians will be able to position the health care industry for growth, maturation and consolidation. It is only through this leadership role that the physician community will be able to affect patient outcome improvements as they relate to the quality and cost of health care.

The second part of this series will address the transition to industry maturity, and will discuss the managed care lessons learned in the urban regions and how they may relate to the semi-rural and rural health care evolution. MoMed

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The Right Heart Catheterization Cooperative Project

Gary J. Fortune, DO, MPH, Frank Schiffel Jr., MA and Susan Elder, MA

Clinical guidelines published by the American College of Cardiology (ACC), conclude that right cardiac catheterization should not be utilized routinely in combination with left coronary angioplasty in patients with coronary arteriosclerosis. In a position statement adopted in 1985 and reaffirmed in 1990, the ACC concluded that in patients with uncomplicated coronary artery disease (CAD), the use of right heart catheterization (RHC), in conjunction with the left heart procedure, contributes to providing additional information in select cases, but its use should be justified by the physician performing the procedure. The Missouri Patient Care Review Foundation (MPCRF), the Peer Review and Quality Improvement Organization for Missouri, sought and received endorsement from the Missouri Chapter of the ACC for the ACC/American Heart Association (AHA) guidelines.[1,2]

In June 1995, based on the ACC consensus, MPCRF visited and initiated the Right Heart Catheterization Cooperative project with six Missouri hospitals in an effort to improve the appropriate utilization of bilateral catheterization for uncomplicated CAD in the acute care setting. In addition, physician-specific comparative statewide statistics were mailed confidentially to clinicians who performed bilateral catheterization. Facilities were selected for project collaboration based on their magnitude of bilateral catheterization for uncomplicated CAD performed in their facility, following retrospective analysis of Medicare claims data.[3]

We hypothesized that a two-pronged approach – disseminating ACC guidelines through a physician-specific and hospital mailing, and visiting identified high utilization facilities would produce a statistically significant reduction in bilateral catheterization for uncomplicated CAD.

Methods

Drawing in part on the success of a similar project in the state of New York, MPCRF conducted a retrospective analysis of the use of right heart catheterization procedures in Missouri. The preliminary analysis utilized Missouri Medicare claims for acute care discharges involving cardiac catheterization during fiscal years 1992 and 1993. The database was obtained via the Health Care Financing Administration (HCFA) and was utilized because it contains information from all Missouri acute care hospitals that perform cardiac catheterization among the state's Medicare population (Medicare Part A).

The analysis was designed to focus on patients with a diagnosis of uncomplicated CAD who underwent bilateral cardiac catheterization and did not have diagnoses that would have indicated the necessity of an RHC. The specific principal CAD diagnoses included in the analysis were acute myocardial infarction, chest pain, angina pectoris and other forms of ischemic heart disease as identified by ICD-9-CM code classification.[4] The case definition of uncomplicated CAD was defined as a patient with a principal diagnosis of CAD, without a concomitant secondary diagnosis of valvular heart disease, arrhythmia, pulmonary

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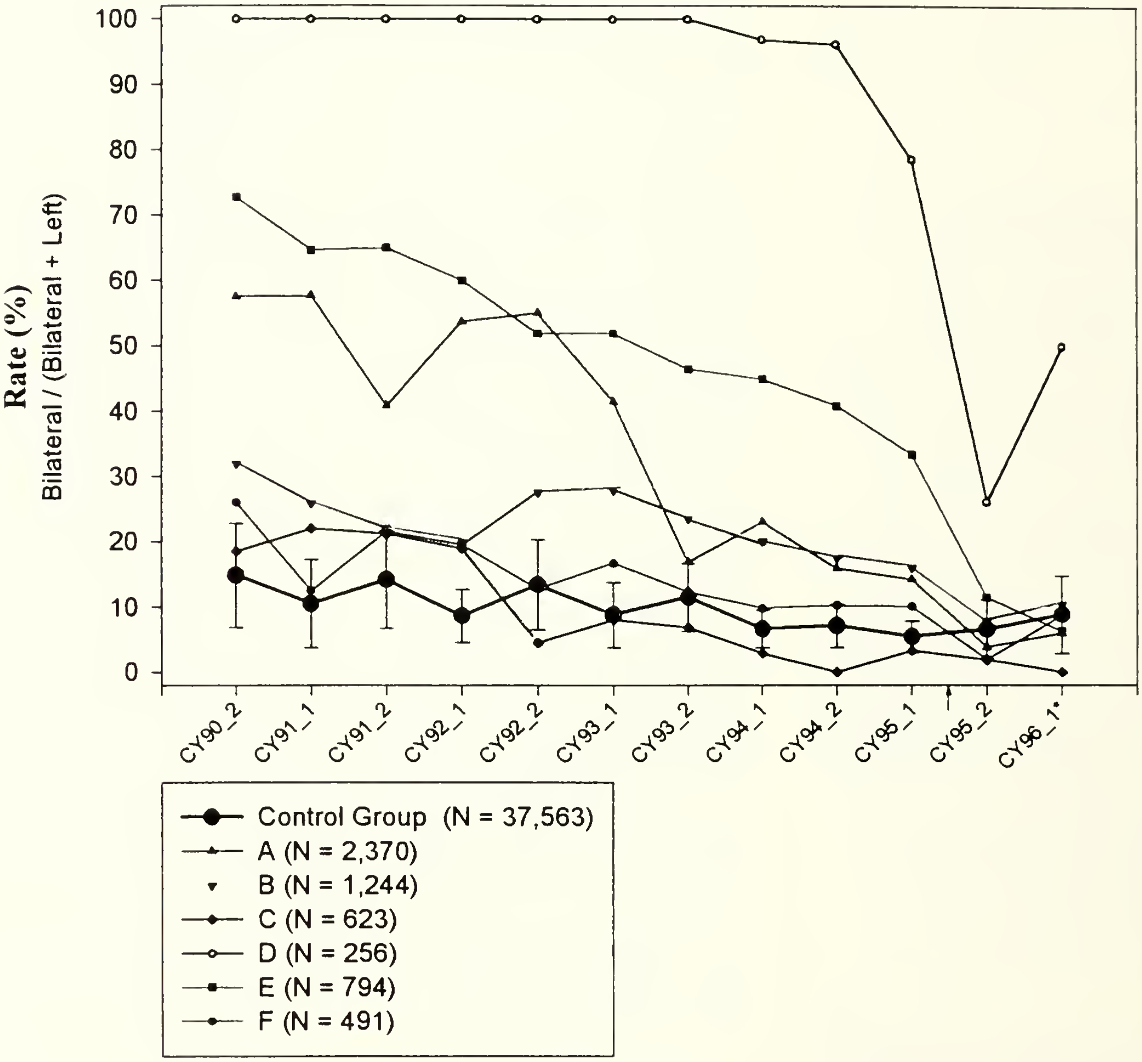
Figure 1

Right Heart Catheterization

Percentage of Bilateral Catheterization for Uncomplicated Coronary Artery Disease
Retrospective Post-Project Monitoring of Six Acute Care Hospitals and a Statewide Control Group
(Calendar Year 1990-1996)



N = Bilateral + Left-Only Cardiac Catheterization

* CY96_1: 1/1/96 - 3/21/96

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disease, congestive heart failure or other cardiac condition that may indicate the potential for cardiac instability. Bilateral catheterization was considered appropriate for these secondary diagnoses, when identified by ICD-9-CM code classification; as such, CAD claims with the above secondary diagnoses were excluded from further analysis.

The preliminary analysis revealed that 64 hospitals in Missouri performed at least one cardiac catheterization during 1992 and 1993. These hospitals, while geographically representing every area of the state, were generally located in or near more highly populated regions. In addition, the analysis indicated that the majority (over two-thirds) of the bilateral catheterizations performed on patients with uncomplicated CAD occurred at relatively few hospitals (N=9), all of which performed such procedures at least 20% of the time. With these results in hand, MPCRF convened a study group of Missouri cardiologists and clinicians to obtain their guidance on the local medical consensus regarding this topic and to discuss methods for providing feedback information to physicians and hospitals. Based on the study group deliberations, it was agreed that MPCRF would confidentially send to each physician and hospital, their own individual data on bilateral catheterization procedures for uncomplicated CAD, along with aggregated statewide data to allow for comparison with their peers.[3]

In the spring of 1995, in conjunction with the physician mailing, MPCRF staff contacted hospitals with high utilization of uncomplicated CAD bilateral catheterization to enlist their participation in a cooperative quality improvement project. As part of this solicitation, MPCRF conducted an on-site meeting at each of the hospitals with representatives of administrative and appropriate clinical staff. The retrospective claims data and analysis were presented, along with the ACC guideline material and the study group recommendations. Participants were encouraged to discuss and deliberate on possible internal (within-hospital) interventions that could be employed to reduce potentially inappropriate bilateral procedures in patients with uncomplicated CAD. At the conclusion of the meeting, each facility was asked to submit a quality improvement plan and to provide monthly status reports on the progress of their efforts. The facilities were apprised that additional claims analysis would be conducted for the pur-poses of post-intervention monitoring, once sufficient time had elapsed for intervention activities to be effectively implemented.

At conclusion of the collaboration phase of the project, six hospitals had agreed to participate in the cooperative project. Several of the providers undertook internal concurrent case review, utilizing a medical record abstraction tool developed by MPCRF, to validate the claim information on bilateral catheterization procedures and to monitor their improvement efforts. Based on the ACC/AHA Task Force Guidelines,[2] the abstraction tool was developed to help the providers determine if bilateral catheterizations were being done routinely, were performed to rule out a right heart disease finding or were necessary due to cardiac instability.

In addition to baseline and follow-up chart audit activities, the participating providers reinforced the intervention initiated by MPCRF, via the physician mailing, by conducting educational meetings with their cardiologists on the ACC guidelines and developing their own mechanisms to feed back information to the physicians on individual and department/division progress in decreasing the rate of bilateral catheterizations for uncomplicated CAD. Several facilities decided to post the ACC guidelines in the cath lab as a reference guide for their cardiologists. Others found it helpful to form an internal quality improvement team to examine the decision process for performing bilateral catheterization and to discern the need for developing an appropriate clinical pathway.

Results

For purposes of the post-intervention monitoring, a retrospective analysis of the percentage of uncomplicated CAD bilateral catheterizations was performed for each of the six participating acute care hospitals

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Table 1. Right Heart Catheterization Project Retrospective Analysis of Missouri Hospitals Performing Bilateral Catheterization for Uncomplicated Coronary Artery Disease

	% Bilateral Catheterizations Pre-Intervention (n) July 1, 1994 to June 30, 1995	% Bilateral Catheterizations Post-Intervention (n) July 1, 1995 to March 21, 1996	P-Value
Facility A	15% (472)	4% (293)	< .05
Facility B	17% (197)	8% (118)	< .05
Facility C	2% (111)	1% (78)	.77
Facility D	87% (54)	31% (29)	< .05
Facility E	36% (132)	10% (111)	< .05
Facility F	10% (89)	4% (74)	.14

SOURCE: MedPro DATA BASE MAY 1996

PERCENT BILATERALS IS THE NUMBER OF BILATERAL CARDIAC CATHETERIZATIONS/LEFT-ONLY HEART CATHETERIZATIONS PLUS BILATERAL CARDIAC CATHETERIZATIONS.

P-VALUE IS DETERMINED BY FISHER'S EXACT AND CHI-SQUARE VARIANCE TESTS FOR HOMOGENITY OF THE BINOMIAL DISTRIBUTION.

Continued from page 659

using five full years (1990-95) and the first three months of calendar year 1996 claims data (Fig. 1). The percentage, for each specific time period at the acute care facility, was derived by dividing the total number of uncomplicated CAD bilateral catheterizations by the total number of uncomplicated CAD bilateral and left-only catheterizations (ICD-9-CM codes 37.23 and 37.22).

A comparison control group percentage of uncomplicated CAD bilateral catheterizations was calculated for non-participating providers (N=44). Confidence intervals were developed for the control group based on the large sample of cases available for analysis (N=37,563). Control group results indicated that the percentage of uncomplicated CAD bilateral catheterization exhibited little variation during the five-plus year time period.

The collaborative effort with the participating providers began in June 1995, which is annotated in Fig. 1 by the arrow to the left of CY 95_2 (last sixth month interval of calendar year 1995). The analysis of the first 3 months of calendar 1996 (CY 96_1) data demonstrated that for five of the six participating providers, the rate of uncomplicated CAD bilateral catheterization decreased to within or below the confidence interval of the control group.

Additional hospital-specific analysis was performed utilizing two comparative periods for the analysis (Table 1). Two time periods were created: a pre-intervention period of July 1, 1994 - June 30, 1995 and a post-intervention interval of July 1, 1995 to March 31, 1996. Chi-square and Fisher's Exact statistical tests were performed on each hospital's data to see if there were statistically significant changes in the rates before and after the implementation of the improvement effort. Four of the six facilities showed a statistically significant change in the rate of uncomplicated bilateral catheterization (p<.05), following project implementation.

The monthly reports provided by MPCRF demonstrated that once the hospital's improvement plan was implemented, including educational sessions with the physicians, a change could be detected in the rate of bilateral catheterization for uncomplicated CAD. This was especially evident at those facilities which established their own ongoing monitoring and feedback mechanisms.

Discussion

The purpose of this project was to analyze the use of bilateral cardiac catheterization in Missouri for patients with a diagnosis of uncomplicated CAD and to identify opportunities for improvement in the appropriate utilization of the procedure. Explanations given by clinician and hospital staff for their high, pre-intervention utilization rates included: prior clinical training that emphasized performing the bilateral procedure routinely and which carried over into future practice; medical record documentation that did not adequately describe the need for bilateral catheterization for complicated CAD cases; or ICD-9-CM coding which did not accurately reflect complicated CAD cases on the claim or which incorrectly coded left-only cases as bilateral. Most of the facilities also acknowledged that, in some instances, unnecessary right heart catheterizations were being performed.

The results of the project indicate that disseminating ACC consensus through physician-specific mailing and provider visitation, with concurrent internal hospital monitoring, can achieve a reduction in the uncomplicated CAD bilateral cardiac catheterization rate in acute care facilities. Using a collaborative, educational approach resulted in the reduction of a potentially unnecessary invasive procedure without influencing the quality of patient care. To monitor the long-term effect of this project, MPCRF will continue to remeasure, on an ongoing basis, the rate of bilateral catheterization for uncomplicated CAD.

MPCRF is the federally designated Medicare peer review and quality improvement organization (PRO) for Missouri under a contract with the Health Care Financing Administration (HCFA). Conclusions and opinions expressed, as well as the methods used, are those of the authors and do not necessarily reflect HCFA policy or perspectives. The authors assume all responsibility for the accuracy and completeness of the PRO data used.

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Microsurgical Treatment of Intracranial Aneurysms

Edwin E. MacGee, MD

An intracranial aneurysm is the most common cause of spontaneous subarachnoid hemorrhage. This problem may affect 20,000 patients annually in the United States and Canada. There is a 50%-60% mortality in these patients from either the initial hemorrhage or repeat hemorrhage within the first year.[1] Aneurysms re-bleed at a rate of 1.5-3% annually.[2] The purpose of surgery is to isolate the aneurysm from the remainder of the circulation and, thereby, prevent further hemorrhage. It also allows for the aggressive treatment of vasospasm.

This paper reports one surgeon's experience with early intervention and microsurgical ligation of 19 aneurysms in 17 consecutive patients. There were 11 good results, 6 fair results, 1 poor result, and 1 death. No patient has re-bled following surgery.

Clinical Data

This series consists of 17 consecutive patients operated on at St. Luke's Hospital in Kansas City from May, 1995, through May, 1996. There were 15 women and 2 men whose ages ranged from 40 to 82 years with 7 in their fifties and 4 were in their seventies. All patients were Caucasian except for one Oriental. All patients had CT scans and cerebral angiography.

There were 3 aneurysms on the anterior communicating artery (ACA), 2 aneurysms on the internal carotid artery by the ophthalmic artery (ICA-OPH), 8 aneurysms on the internal carotid artery by the posterior communicating artery (ICA-PCOM), 5 aneurysms on the middle cerebral artery (MCA), and 1 aneurysm on the superior cerebellar artery of the posterior circulation (POST). Seven aneurysms were on the left and eight were on the right side. Two patients had multiple aneurysms. One of these patients had bilateral ICA-PCOM aneurysms and the other had bilateral MCA aneurysms. Ten patients had a history of hypertension.

A modification of the Hunt and Hess patient grading system was utilized (Table 1). An effort was made to operate on these patients early after their SAH. After admission, angiography was done. A family conference was completed involving the operating surgeon, a clinical nurse specialist, and the hospital chaplain. Surgery was then done. Eight patients were operated on within 3 days after their SAH. Five patients were operated on 4-6 days after their SAH. One patient was operated on 14 days after SAH. Her initial angiography was negative. One patient was operated on 20 days and another 24 days after their SAH. These delays were necessitated because of angiographic complications. These were noted at the time of cerebral angiography and were manifest by coma and decerebrate posture. There was no evidence of repeat SAH. These symptoms improved over the next 2-3 weeks. All patients except one had SAH. An effort was made to follow the operative technique of Yasargil.[4-5] McFadden variangle and Yasargil aneurysm clips were used.[6] Intraoperative angiography was used in selected patients.

Thirteen patients were dismissed within 3 weeks after admission. The shortest stay was 4 days. Four patients were dismissed 3-8 weeks after admission.

There were 11 good results, 6 fair results, 1 poor result, and one death. Patients listed under good results are those who returned home to their previous occupation with no neurologic deficit or minimal and non-disabling neurologic deficit. Patients with fair results were those who returned home with a moderate neurologic deficit such as memory disturbance or hemiparesis. Patients with poor results survived with a severe neurologic deficit.

Three patients required reoperation to remove mass lesions. One patient had an intracerebral hematoma and one had an epidural hematoma. Both patients made good recoveries. One patient had removal of subdural trapped air. She had a fair result.

There was one death. This was a 50-year-old woman with a history of hypertension and lifelong "migraine" headaches. She had a large ICA-OPH aneurysm on the left side. Her aneurysm ruptured prematurely intraoperatively with resultant significant blood loss despite a balloon catheter in the proximal carotid artery. Eventually her aneurysm was trapped by occluding her internal carotid artery. She died on the sixth post-operative day of a cerebral infarct.

One patient had a ventriculostomy two days prior to her craniotomy because of acute hydrocephalus. She made a good recovery. Three patients had lumbar-peritoneal shunts, each about one month post-op, because of persistent hydrocephalus. Two patients had fair results and one was a poor result. Hydrocephalus may result acutely from intraventricular hemorrhage or later from an inflammatory impairment of the CSF resorptive mechanisms in the arachnoidal villi. Symptoms of hydrocephalus include altered conscious state, dementia, incontinence, and ataxia. Treatment may require ventriculostomy, repeated lumbar puncture, or a shunting procedure.

Vasospasm is an angiographic diagnosis and occurs in the larger cerebral vessels. It typically presents as a subacute deterioration in the patient's mental status, with or without ischemic neurologic deficit. It usually begins 2-4 days post-SAH, peaks on days 5-8, and resolves in about 2 weeks. It is due to the breakdown of red blood cells in the subarachnoid space with the release of vasoactive substances such as serotonin, prostaglandins, and catecholamines. It is more severe in patients with major SAH and correlates with the amount of blood in the subarachnoid space seen on computerized tomography. Vasospasm occurred in 7 patients. Vasospasm was treated with hemodilution, hypervolemia and hypertension. Nimodipine is a calcium channel blocker specific for cerebral vessels. Treatment is begun when the diagnosis of SAH is established, and maintained with 60 mg q 4 h for 21 days. It improves neurological outcome by reducing the incidence and severity of ischemic deficits. All patients had a Camino intracranial pressure monitor, lumbar subarachnoid drain, arterial line, and Swan-Ganz catheter. Five patients with vasospasm had good results and two patients had fair results. Table 2 shows the surgical results according to location of the aneurysm. Table 3 shows the results according to pre-operative grade.

Table 1. Classification of Patients with Intracranial Aneurysms According to Surgical Risk (HUNT and HESS)

I	Asymptomatic
II	Headache, nuchal rigidity, no neurological deficit other than cranial nerve palsy
III	Drowsiness, confusion, or mild focal deficit
IV	Stupor, moderator to severe hemiparesis, possibly early decerebrate rigidity and vegetative disturbances
V	Moribund

Table 2 - Surgical Results According to Location of Aneurysm

Artery	Good	Fair	Poor	Death
ACA		3		
ICA-PCOM	5	2	1	
ICA-OPH	1			1
MCA	4	1		
POST	1			

Table 3 - Surgical Results According to Patient's Preoperative Grade

Grade	Good	Fair	Poor	Death
I	3			
II	5	2		1
III	2	3		
IV	1	1		
V			1	

Seizures after SAH may increase the possibility of rebleeding. Consequently, patients are given an anticonvulsant, typically phenytoin (loading dose, then 300 mg daily for 1-2 months post-SAH).

There were no wound infections. Prophylactic antibiotics were used routinely. Cefazolin, 1 gm 1 q 8 h was used for as long as a central line, subarachnoid drain, or intracranial pressure monitor were in place. No patient has re-bled following surgery.

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Discussion

In 1966 it was stated that a 30-33% overall mortality rate under the conditions listed in the cooperative study could be used as a guideline by the average neurosurgeon.[7] Following the intracranial surgery there was a useful functional survival of 46% among those patients with single aneurysms. Thus, 54% of individuals with single aneurysms subjected to intracranial surgery either died or were economically incapacitated. In 1972, Yasargil reported a 1.6% mortality in 250 patients with preoperative grade I-III.[4] This led Sugar to state that "these results are fantastically superior to those of anyone else."[8] This striking improvement was due primarily to the use of micro-surgical technique and minimal brain retraction. In 1975, Yasargil reported his series of 505 patients operated on from 1967-1974 with an overall mortality of 4%. The Mayo Clinic experience with 1,947 patients who underwent surgery between 1969 and 1990 showed that 1,445 had an excellent outcome, 231 had a good outcome, 171 had a poor outcome and 100 (5%) died.[9] LeRoux et al reviewed the incidence of surgical complications in 355 patients undergoing repair of anterior circulation aneurysms at the University of Washington between 1983 and 1993.[10] They concluded that, except for severe cerebral swelling associated with intracerebral hemorrhage, the risk of surgical complications is similar in good and poor grade patients. In a survey of the literature, they found that between 5 and 20% of patients may develop new neurologic deficit following surgery and that intraoperative aneurysm rupture is esti-mated to occur in 14-35% of patients.

Ogilvy et al analyzed 132 consecutive aneurysm clippings at the Massachusetts General Hospital from 1991 to 1993.[11] They had an overall stroke rate (clinical and radiologic) of 9.8%. They found that stroke was unlikely to occur when temporary clip times lasted less than 20 minutes and that intraoperative aneurysm rupture was significantly associated with stroke outcome.

The present small series compares favorably with the author's previously reported series and with other series regarding morbidity and mortality.[12]

Synopsis

Subarachnoid hemorrhage from an intracranial aneurysm is a frequently fatal but potentially curable problem. Surgery is done to prevent further hemorrhage and it allows for the aggressive treatment of vasospasm. This article reports one surgeon's experience in the past year with early intervention and microsurgical ligation of 19 aneurysms in 17 consecutive patients. There were 11 good results, 6 fair results, 1 poor result and 1 death. No patient has re-bled following surgery.

Acknowledgment

The author would like to thank Chaplain Jerry Kolb, Kay Carpenter, RN, Gene Bode, MD (Neuroanesthesia), and Graham Lee, MD (Neurology) for their assistance in the care and treatment of these patients.

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2. Publication No.: 0355-3800
3. Date of Filing: September 30, 1996
4. Frequency of Issue: Monthly
5. No. of Issues Published Annually: 12
6. Annual Subscription Price: $60
7. Compete Mailing Address of Known Office of Publication:
   113 Madison, P.O. Box 1028
   Jefferson City, MO 65102
8. Complete mailing addresses of Publisher, Editor, and Managing Editor:
   Publisher: Mo. State Medical Assoc.
   113 Madison, P.O. Box 1028
   Jefferson City, MO 65102
   Editor: J. Regan Thomas, MD
   113 Madison, P.O. Box 1028
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   Managing Editor: Angela Allen
   113 Madison, P.O. Box 1028
   Jefferson City, MO 65102
10. Owner: Mo. State Medical Assoc.
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11. Known Bondholders, Mortgages, and Other Security Holders: None
12. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes has not changed during the preceding 12 months.
13. Publication Name: Missouri Medicine
14. Issue Date for Circulation Data Below: June 1996

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On the Cover:
"Table Rock Lake Memory" is an acrylic painting by Terry Martin. Mr. Martin is an associate professor of fine art at William Woods University in Fulton, Missouri.

Editor's Desk

"Times Are Changin'"

J. Regan Thomas, MD, Editor

No news here, HMOs continue to grow and the effects of managed care are increasingly evident in Missouri as throughout the nation. It is interesting to look back on the past few years and observe one of the ironies related to health care. During the early Clinton administration enormous attention was focused on what was anticipated as greater government control and involvement in medical care. The medical community was not alone in this observation, the media shared the assumption of this forgone conclusion. Once the Clinton initiatives went by the wayside, it began to become evident that most individuals had overlooked the significance of the real driving force in health care reform. The real catalyst was from the private sector. The commitment to enlarge and expand managed care concepts came from employers and industry rather than government.

HMOs as a group have now grown to the point where they are an industry in their own right. They have independent objectives and generate huge profits and accordingly have developed significant clout. Ironically, they now have enough clout to impact the government rather than the other way around, as many thought would be the case a few years ago.

The *American Medical News* reported in January 1996 that membership in managed care is growing by more than 11% a year and is anticipated to include over 65 million persons by the end of 1996. Nationally, the number of Medicaid beneficiaries that moved into managed care doubled between 1993 and 1994.

Physicians as a group tend to be concerned with how managed care effects patient care (there is indeed a difference). Those physicians who are unhappy with managed care growth should remember that they are the single group who had the potential early on to halt its growth. Any real health care plan depends on physicians to ultimately provide that care. If physicians as a group simply had refused to participate it would not have progressed. But of course it was more complicated than that and economic pressure to participate was too great for most physicians to resist. Many (and now probably most) gradually became managed care providers in one fashion or another. Not many doctors could face the economic risks of not participating. As more joined in, it became more difficult to remain on the outside.

Now the so called marketplace is the primary driver of the changes in providing health care. Managed care in its various forms including HMOs is continuing to grow at an accelerated rate. The *American Medical News* reported in January 1996 that membership in managed care is growing by more than 11% a year and is anticipated to include over 65 million persons by the end of 1996. Nationally, the number of Medicaid beneficiaries that moved into managed care doubled between 1993 and 1994.

With those trends, it is interesting now to see the change in attitudes of many physicians. Now instead of efforts to slow the progress of HMOs, many doctors are fighting to join their ranks. All this in direct contrast to the attitude a few years ago. A case in point is the support for "any willing provider" legislation. In numerous states physicians have lobbied for enactment of laws to guarantee a physician access to a network if they are willing to abide by the terms and conditions of the network. Wyoming in 1995 passed an "any willing provider" law even though they had no

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HMOs in the state at the time. Some argue that these laws are passed to slow or hamper the impact of HMOs by diluting the capacity of managed care plans to pressure physicians to grant volume discounts and lower reimbursement levels. Others would say it simply points out the physicians desire to jump on board the HMO bandwagon and avoid being left in the void.

More changes are likely to continue over the next few years as managed care and the various health care delivery alternatives continue to mature. It will be interesting in the future to look back on those changes, how they evolved, how they were accepted or rejected, and how we as physicians reacted. Certainly, the Bob Dylan verse, "the times are a changin'" is appropriate for these times as well. MoMed

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Membership Notes

Steven D. Atwood, MD, an internist in private practice in Springfield, Missouri, received a special recognition award from the American Society of Internal Medicine (ASIM) at the Society's 40th Anniversary Meeting. ASIM confers annual special recognition awards on members who have performed outstanding service to the specialty Society and the patients it serves. Only two special recognition awards were given this year. Dr. Atwood is recognized as a solid contributor to the advancement of patient care in both Oklahoma and Missouri. His areas of special interest are critical care, oncology and pharmacology. Dr. Atwood is the current membership chair of the Missouri Society of Internal Medicine (MSIM), and serves as a member of the MSIM council. Dr. Atwood was also recognized by MSIM as its 1996 Distinguished Internist of the Year for his outstanding effort in developing the MSIM membership database.

George Carr, MD, a family physician at St. Mary's Health Center in Jefferson City, Missouri, has received the degree of Fellow of the American Academy of Family Physicians (AAFP). The Association represents 83,000 family physicians, residents in family practice and medical students. There are more than 25,000 AAFP Fellows nationwide.

William M. Fogarty Jr., MD, FACP, clinical professor of internal medicine at St. Louis University, received the Missouri Laureate Award from the Missouri Chapter of the American College of Physicians (ACP). The award honors Fellows and Masters of the ACP, who have demonstrated by their example and conduct an abiding commitment to excellence in medical care, education, or research, and in service to their community, their Chapter, and the ACP. Dr. Fogarty is an active leader in the St. Louis medical community. He was recognized as a superb physician, teacher, and mentor. He was elected to the Council of the Missouri Chapter ACP in 1991, and to Fellowship in the College in 1993. He served on the Missouri Chapter Health and Public Policy Committee since 1991 and was elected to the National Health and Public Policy Committee in 1995. In 1995, ACP appointed him to the Joint Commission for the Accreditation of Health Care Organizations.

Jay F. Piccirillo, MD, assistant professor of otolaryngology, medicine and occupational therapy at Washington University, received a two-year grant from the National Cancer Institute for a research project titled "The Inclusion of Comorbity in Oncology Data Registries."

Robert W. Thompson, MD, assistant professor of surgery at Washington University, received a one-year award from the Pacific Vascular Research Foundation as the 1996 Wylie Scholar in Academic Vascular Surgery.

*MSMA members' honors and achievements including election or appointments to national or state offices, awards, academic appointments and grants may be sent to **Missouri Medicine**, 113 Madison, P.O. Box 1028, Jefferson City, MO 65102.*

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In Memoriam

Don A. Black, MD, 76, Prairie Village, Kansas, died September 21, 1996. Dr. Black served in the Medical Corps during World War II in France and Germany. He received his medical degree at the University of Kansas in 1953, and was a member of the Nu Sigma Nu medical fraternity. Dr. Black practiced medicine from 1954 to 1988, and was a founder of Kansas City Internal Medicine group. He was a member of the Kansas City Society of Internists, American Diabetes Association, and Kansas City Heart Association. He served as treasurer of the Metropolitan Medical Society of Greater Kansas City. Dr. Black was president of the Research Medical Center Medical Staff in 1968, and in 1993 was awarded the Medical Staff Distinguished Service Award.

William H. Meinberg, MD, 91, Northridge, California, died September 30, 1996. Dr. Meinberg received his medical degree at Washington University in 1932. He practiced ophthalmology in St. Louis for 50 years. He moved to Northridge, California in 1982 after retiring in 1975. Dr. Meinberg was a member of the St. Louis Metropolitan Medical Society, Missouri State Medical Association, California Medical Association, St. Louis Ophthalmic Society, and American Academy of Ophthalmology.

Robert J. Mueller, MD, 84, St. Louis, Missouri, died September 29, 1996. Dr. Mueller received his medical degree at Washington University in 1936. After graduation he became chief resident in psychiatry and neurology at the University of Rochester School of Medicine in Rochester, New York. He also was a resident at Rochester Municipal Hospital and Strong Memorial Hospital in New York. Dr. Mueller later received a master's degree from the University of Michigan at Ann Arbor while he was chief resident at the university's hospital. He was a captain in the Army during World War II. After the war, he returned to St. Louis and started his practice in south St. Louis. Dr. Mueller, a psychiatrist and neurologist, maintained a practice for about 55 years in Hampton Village Medical Center and was on the staffs of many area hospitals. He was a consultant and physician emeritus at many area hospitals after he retired in 1986. Dr. Mueller was a member of the Mu chapter of Phi Beta Pi, the American Psychiatric Association, American Medical Association, and many other medical associations from which he received many awards.

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Emory University; 1972

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Robert W. Tolan, *St. Louis*
Michael W. Vannier, *St. Louis*
Julian N. Verde, *St. Louis*
Stephen J. Vitale, *Chesterfield*
Lynn J. Walley, *Hannibal*
Gary S. Wasserman, *Kansas City*
Charles L. Weinstein, *Kansas City*
Ronald R. Weis, *Kansas City*
John S. Whitten, *Cape Girardeau*
Ronald P. Wilbois, *St. Louis*
Gerald A. Wolff, *St. Louis*
James C. Wright, *Perryville*
Charles H. Zerr, *Independence*

Radiology Quiz #9

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

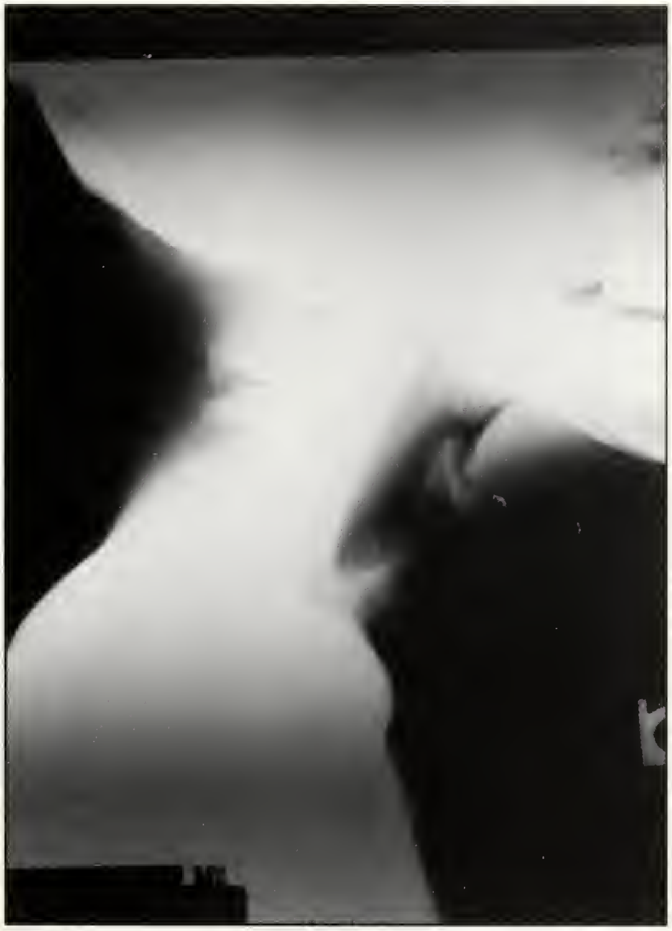


Figure 1

A 13-year-old boy presented with a sore throat and swallowing difficulty. A soft tissue lateral view of the neck was performed (Fig. 1).

What is the diagnosis?

a. Croup
b. Acute epiglottitis
c. Retropharyngeal abscess
d. Normal

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.

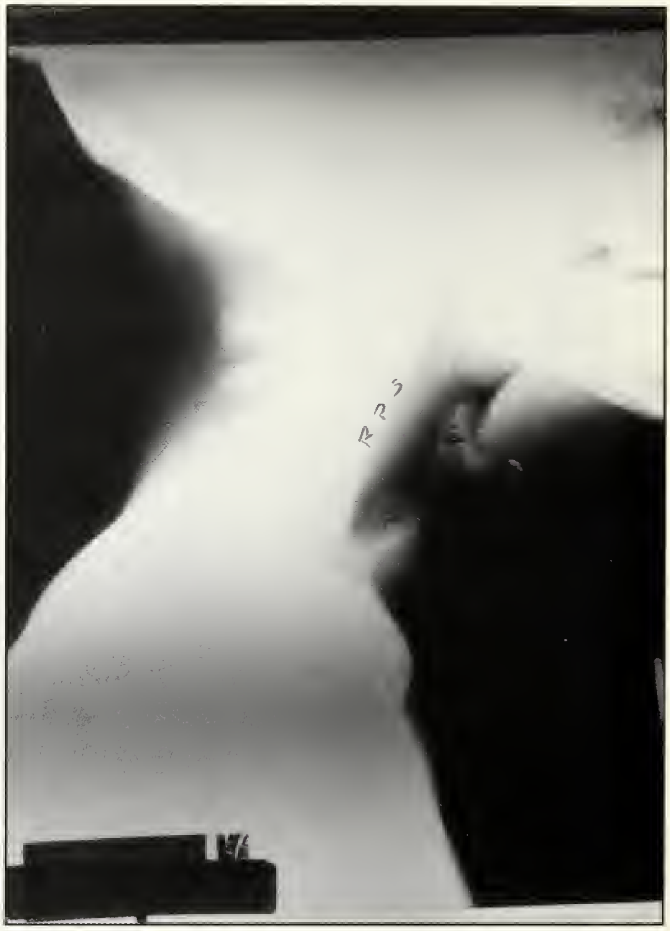
ANSWER: b. Acute epiglottitis

The correct answer is Option B, acute epiglottitis. There is marked enlargement of the epiglottis (E in repeat Fig. 1), visualized as a rounded mass at the base of the tongue and posterior to the hyoid bone. There is also thickening of the aryepiglottic folds (F), part of the supraglottic inflammatory process. There is also distention of the hypopharynx, indicating upper airway obstruction.

Acute epiglottitis is a potentially life threatening supraglottic infection, usually caused by H. Influenza. Peak age incidence is 3 to 7 years, but it can also be seen from adolescence to old age. Recognition is important due to the potential for airway obstruction and death. Radiographically, patients with epiglottitis show enlargement of the epiglottis on lateral neck radiographs. The enlarged epiglottis has a bulbous appearance like a thumb in profile, rather than the slender appearance of the normal epiglottis. Some investigators have recommended measurement of the width of the aryepiglottic folds to assess the degree of supraglottic inflammation.

Option A, croup is incorrect, since the subglottic trachea is not narrowed in this case. Croup or laryngotracheobronchitis is a subglottic inflammation which is usually caused by the parainfluenza virus. Peak age incidence is 6 months to 3 years. Subglottic edema with tapered narrowing of the trachea may be seen as a "steeple" sign on frontal chest radiographs.

Option C, retropharyngeal abscess is incorrect since the retropharyngeal soft tissue space (RPS) does not appear abnormally widened. A space wider than 15 mm in young children, or wider than 7 mm in older children and adults, is considered abnormal.



Repeat Figure 1

References

1. Emergency Radiology Syllabus, American College of Radiology, 1979, pp. 224-232.
2. John, S.D. et al. Aryepiglottic fold width in patients with epiglottitis: Where should measurements be obtained? *Radiology* 1994;190:123.

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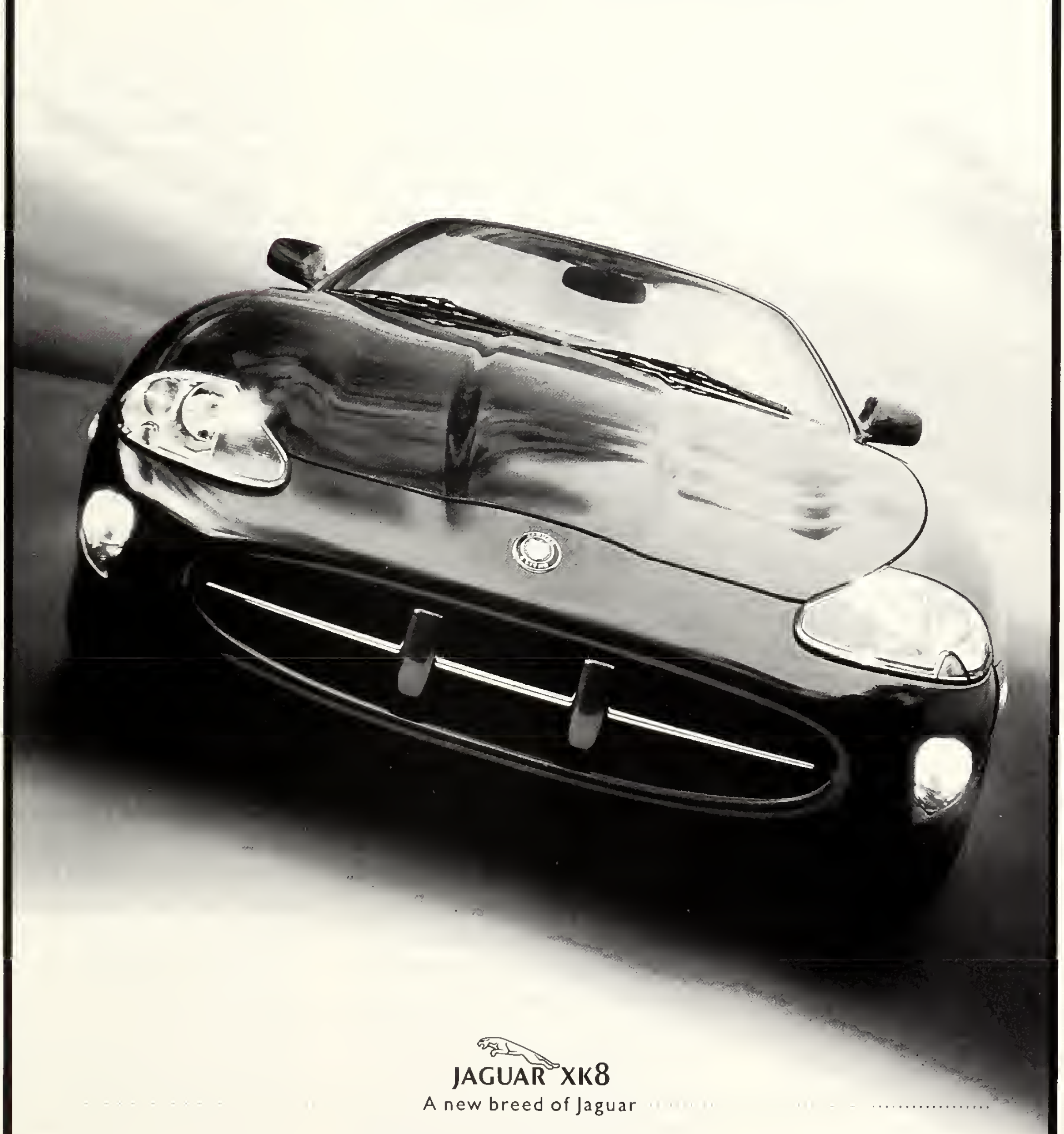

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The Citizen Attorney General and Medicare Fraud

A. L. DeWitt, RRT, CRTT, JD

Fraud is Big Business

Recent reports by the federal government estimate that as much as 10% of the federal Medicare budget is expended on fraudulently charged items. Ten percent of a multi-billion dollar budget is part of the reason that the federal government, through the Office of The Inspector General of the Department of Health and Human Services, has recently been cracking down on Medicare fraud. Academic medicine, with its residents and interns, has been one source of significant Medicare settlements. But all physicians need to know where the bulk of the government's fraud recoveries come from – private citizens. That's right, private "attorneys general" account for more than half of the recoveries to treasury of fraudulently charged federal payments. The reason may surprise you – the federal government pays a handsome reward to those who disclose fraud.

A Little History

In 1863 the nation was being torn apart by a bitter civil war, and many of the Union's troops did not get the material and supplies they needed. Union army officers, at that time empowered to requisition from the public, would give receipts for horses and supplies, and those receipts would be altered to increase the profit. Worse, supplies bought on the open market were often substandard. The economic cost of the war was draining the federal treasury. Abraham Lincoln wanted to stop this looting of the Treasury, and implored Congress to pass the False Claims Act. Codified at 31 U.S.C. § 3729 et seq., the law provides a unique mechanism for policing fraud because it allocates a portion of the government's recovery, between 15% and 30%, to the person who discloses the fraud. This reward, which averages 17% of the amount recovered, is a powerful incentive to disclose fraudulent transactions. Ask Jack Dowden.

Dowden is the California man who several years ago turned-in a former employer and one other medical laboratory for fraudulent billing. The laboratories were overbilling Medicare by about $8 per test. Under the terms of the act these $8 tests were worth somewhere between $5,024 and $10,024 to the federal government. When the laboratories settled the proceeding for something in excess of $200 million Dowden pocketed more than $20 million as a reward. How did an $8 overcharge become a $5,024 to $10,024 liability? Because the False Claims Act provides for treble damages ($8 x 3 = $24) and for civil penalties between $5,000 and $10,000 for violators.

Physician Liability

Suppose a physician charges $45 for a routine office visit, and $65 for an extended visit. One day, completely without the doctor's knowledge or direction, a staff member decides that the doctor can make more money (and pay a larger Christmas bonus) if all Medicare patients are billed for an extended visit as opposed to a routine visit. Before the physician discovers the error, and puts a stop to it, he or she has billed the additional $20 to Medicare on 200 different patients. The physician has potential liability under the False Claims Act that is actually staggering. Under the provisions of the law, the $20 overcharge is trebled to $60, so a total treble damage award of

$12,000 is possible. But worse, the civil penalty provisions of the law impose an additional amount between $5,000 and $10,000 for each separate false claim submitted. The physician is looking at a total potential liability of $1 million to $2 million in civil penalties for this overbilling.

There are some safeguards built into the law that are meant to protect the truly innocent. The law requires that the violation of the law for billing regulations be done knowingly. Under common law rules the physician might escape personal (but not necessarily corporate) liability by showing that they had no actual knowledge of the false billings. But under the False Claims Act the standard is not actual knowledge, but whether the doctor "knew or should have known" of the billing errors. If the physician's revenues went up without a noticeable change in patient volume or acuity, or other alteration in practice pattern, the physician might be liable for failure to inquire into the circumstances of the increased cash flow. Worse, if the physician is held liable under the act for the intentional act of defrauding the government, the normal protections available to a negligent physician under the Bankruptcy Code may not apply.

But the analysis does not stop here. Suppose the physician, seeking to avoid paying back the overcharges amounting to $6,000, simply goes back and alters the 200 medical records and billing sheets to indicate that the office visits actually were extended visits. If the doctor does this, it may run afoul of language in the act making it unlawful to create a false record in support of a false claim, or other language making it unlawful to avoid repaying the government for overpayments. Under either of these two sections the full civil penalty and treble damage provisions apply, again rendering the doctor liable for substantial civil damages.

Cognitive Dissonance

The tendency is to think that false billings are not likely to be discovered, and that "it won't happen to me." Nothing is further from the truth. In most cases fraud is discovered when a former employee discloses the shenanigans to the attorney they have hired to pursue the wrongful termination claim. Often the attorney tells the client "we can't sue the doctor for firing you, but there may be another way to get some justice for you." Given the incentive of a huge recovery, even the most loyal of former employees can be induced to offer evidence and testimony against their former employers. In fact, two of the cases in our office currently under seal, came about as the result of the firing of an individual who knew about the fraudulent transactions. Another case came to our office by a member of the patient's family who, when reviewing the billings, saw fraudulent transactions reported.

The False Claims Act has numerous provisions which give the government the power to subpoena office records, and federal agents have been known to raid offices seizing hundreds of financial documents in order to prove a false claims case. Because the case is filed under seal, (to give the government time to investigate) a physician or hospital may not even know it has been sued until six to nine months after the action has been placed on file, and may only find out about it then when the FBI agents show up with a search warrant.

If a physician has questions about billing practices, and the False Claims Act, the best advice is to see an attorney who specializes in health care law. By voluntarily disclosing overbilling and repaying the amount to Medicare, clinicians can avoid the huge penalties imposed on those unlucky enough to be turned in by a former employee or partner. Under no circumstances should incorrect billing or procedures be left to take care of themselves. The result could be financial ruin for the unsuspecting clinician.

The Author

A. L. "Tony" DeWitt is a former respiratory therapist and hospital department manager who began practicing law in 1993. His practice with Shamberg, Johnson & Bergman, of Kansas City, Missouri, is limited to medical negligence and False Claims Act cases involving hospitals and nursing homes.

Pension Simplification?

Steven L. Finerty and Sean Duggan

The 1996 year has been a busy one for Congress as three separate pieces of major legislation that impact retirement plans, IRAs and other types of employee benefit plans were passed. Some of the legislation is good, some bad and some will have little or no effect.

Due to space constraints, we will focus on the provisions that affect qualified retirement plans (401(k), Profit Sharing and Pension plans) and IRA accounts.

If you sponsor a qualified retirement plan, your plan must be amended by the last day of the plan year for your plan year beginning in 1998. We do not recommend amending your plan at this time, however, as some effective dates are a few years away and there is always the possibility provisions could be changed.

The good news first:

Repeal of Family Aggregation rules

This is probably the most important of all "pension simplification" provisions. Its repeal will allow practices where both the husband and wife (and any minor children under age 19) who work at the practice to count up to a maximum of $150,000 of compensation for each person. Before the repeal the married couple only had one $150,000 compensation limit. Example:

	Under Old Laws	Under New Laws
Dr. Compensation	$150,000	$150,000
Spouse Compensation	$ 25,000	$ 25,000
Jr. Compensation	$ 10,000	$ 10,000
Total Family Compensation	$185,000	$185,000
Total Allowable	$150,000	$185,000
Compensation	x15%	x15%
Maximum Contribution	$ 22,500	$ 27,750

(Effective for Plan years beginning after 12/31/96.)

Spousal IRA

A spouse without any compensation is eligible to make a deductible $2,000 IRA Contribution. The old limit was $250.

Benefit: An individual who doesn't participate in a qualified retirement plan and a non-working spouse can make a total deductible IRA contribution of $4,000. For married physicians who participate in a qualified retirement plan and earn more than $40,000, the IRA contribution can still be made, but it will not be deductible. Earnings on all IRA contributions compound tax-deferred. **(Effective 1/1/97)**

Combined defined contribution-defined benefit plan limits repealed

Under the current rules, plan sponsors who have a defined contribution (DC) and a defined benefit plan (DB) are required to do complex and costly testing to ascertain whether any employees need to have their contributions limited in one of the plans. Under the new law this requirement has been repealed, although the effective date of the law is not until 1/1/2000.

Benefit: A plan sponsor may have both a DC and DB plan and will not have to do the complex and costly testing. Business owners nearing retirement who sponsor one or more DC plans may want to discuss adding a DB plan with their advisor. You may be able to contribute significantly more under this arrangement than the stand-alone DC plan. **(Effective for plan years beginning after 12/31/99)**

Repeal of 15% excise tax on excess distributions

One of the most punitive provisions in the tax code is the 15% excise tax which can apply when a plan participant with a large plan balance takes withdrawals from the plan in excess of $155,000 (as indexed). For income tax purposes the excise tax on excess distributions has now been repealed for the years 1997, 1998 and 1999. (For Estate Tax purposes, the Excess Accumulations Tax has not been repealed.)

Benefit: You will be able to make withdrawals from your qualified plan or IRA balance of any amount for three years without paying the 15% excise tax on the distribution. For some this may have a significant impact for estate planning purposes. Before you decide to take advantage of this provision, have a thorough analysis done by your financial advisor. Frequently future excise taxes are not nearly the problem they might seem. **(Effective 1997, 1998 and 1999)**

Repeal of Minimum Distribution rules

Qualified plan participants will no longer have to take required distributions until after they retire. **This provision does not apply to 5% or more owners of a business or practice. Those physicians who are sole proprietors or own at least 5% of the medical practice will still be required to take a required distribution upon attaining age 70 1/2.**

Benefit: For those who are not required to take a distribution, retirement plan account balances will be able to continue to grow tax-deferred until they retire. **(Effective 1997)**

Simplified Definition of Highly Compensated Employee:

The definition of a Highly Compensated employee has been simplified to include:

1. 5% or more owners.
2. Employees who earn more than $80,000 in the prior plan year. (The employer can further limit the number of highly compensated employees by including only those in the top-paid 20% of employees earning $80,000.)

Benefit: Plan sponsors will know exactly who the highly compensated employees are for the current plan year. Under the old rules you would typically have to wait until after the plan year to determine who was a highly compensated employee. For the 1997 plan year plan sponsors may use compensation earned in the 1996 year to determine highly compensated employees. **(Effective for plan years beginning after 12/31/96)**

ADP testing simplified

Starting in 1997, 401(k) Plan sponsors will find administering "deferral percentage tests" much easier. That is due to the fact that the actual deferral percentage for the non-highly compensated employees from the prior year may be used as the percentage deferral for current year testing. For example, if the average deferral percentage of non-highly compensated employees was 4% for the 1996 plan year you may elect to use that 4% figure for the deferral percentage test for the non-highly compensated employees for the 1997 plan year. Similar provisions are available for the matching contributions.

Benefit: Plan sponsors will know the highest permissible average deferral percentage of the highly compensated employees for the current year as soon as the prior year's test has been completed. This will go a long way in eliminating refunds of excess contributions and possible excise taxes on those contributions. **(Effective for the plan year beginning after 12/31/96)**

415 Compensation redefined

Section 415 compensation is the compensation that is used to determine an individual participant's maximum annual addition. (For DC plans this is currently the lesser of 25% of 415 compensation or $30,000.) The new definition of 415 compensation includes salary deferrals made under 401(k), 403(b), SEP, 457 and 125 (Cafeteria) plans.

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For example:

	Under Old Law	Under New Law
Compensation:	$70,000	$70,000
Salary Deferrals	9,500	9,500
415 Compensation	$60,500	$70,000
	x25%	x25%
Maximum annual addition	**$15,125**	**$17,500**
Less 401(k) deferrals made	$9,500	$9,500
Remaining annual addition amt.	**$5,625**	**$8,000**

In the above example the participant is able to get an additional $2,375 contributed to his or her account. This will particularly benefit lower paid employees who defer large portions of their salary. **(Effective for plan years beginning after 12/31/97)**

401(k) Plans for tax-exempt employers

The new laws have had a sweeping effect on tax-exempt and governmental plans. If you are a tax-exempt employer we advise you to carefully review all deferred compensation programs carefully in light of the new laws. Of greatest importance, the new provisions allow for tax-exempt employers to once again sponsor 401(k) plans.

Benefit: Tax-exempt employers will now have the choice to sponsor either a 403(b) plan or a 401(k) plan. **(Effective for plan years beginning after 12/31/96)**

There is also some bad news in the new tax law:

Repeal of $5,000 Death Benefit Exclusion

Under old rules the beneficiary of a deceased plan participant was able to exclude the first $5,000 received from the qualified retirement plan from their gross income (subject to some requirements). This has been repealed.

Repeal of 5-year averaging for lump-sum distributions

The new law has repealed the 5-year forward averaging option for lump-sum distributions. The repeal, however, is not effective until the year 2000, so if you were going to use this option in a future year, you may still have time.

Finally, there are two additional changes which had the potential to be the most far reaching retirement plan simplification reforms ever enacted. However, the rules fell far short of their potential due to provisions requiring plan participants to be 100% vested as soon as they become eligible:

Safe harbor provision to avoid deferral percentage testing for the 401(k) Plans:

Under the new law a 401(k) plan may avoid deferral percentage testing entirely by providing one of the following:

1. An Employer Profit Sharing contribution of at least 3% of compensation to **all** eligible employees, or
2. Matching contribution of at least 100% of an employee's deferrals up to the first 3% of compensation, plus at least 50% of an employee's deferrals from 3% to 5% of compensation.

As stated above, the problem with this provision is the above contributions **are required to be 100% vested. (Effective for plan years beginning after 12/31/98)**

SIMPLE Plans

A business with no more than 100 employees will be able to adopt a SIMPLE Plan. These are plans similar to 401(k) Plans except the maximum employee deferral is $6,000 and the maximum employer contribution is limited to either (1) a 100% match on the first 3% deferred or (2) the company is required to make a 2% Profit Sharing contribution. Both contribution types are 100% vested. As a result, the appeal of a SIMPLE Plan will likely be very limited.

Overall, it appears that the government has made more worthwhile changes that should simplify many of the more complex situations that arise in sponsoring a plan. This article is in no way a comprehensive analysis of the three laws that were passed, but is a highlight of the provisions that will likely affect you. We advise you to consult with your financial advisors on how the new laws affect you and your plan. MoMed

Steven Finerty, JD, CFP is a principal of Moneta Group, Inc., the MSMA endorsed financial services firm for retirement and financial planning. **Sean Duggan** is a qualified plan consultant for Moneta Group, Inc.

Collaborative Practice Arrangements Require Careful Forethought

Tom Holloway, MSMA Director of Government Relations

To eliminate legal uncertainties regarding physicians who delegate responsibilities to nonphysician providers, the 1993 Missouri General Assembly enacted legislation giving physicians the clear statutory authority to enter into collaborative practice arrangements with registered professional nurses.

In early 1993, improving access to health care was a political imperative and there was a strong nationwide trend to grant wide independent practice authority to nurses and other nonphysician providers. House Bill 564 was a vast health care reform package within which collaborative practice was one of several central elements. It enjoyed considerable support.

Early versions of the collaborative practice component offered inadequate protection for physicians and their patients. One variant would have granted nurses independent practice authority.

MSMA lobbied intensely to effect needful improvements, and the bill slowly evolved. Countless hours of negotiations resulted in myriad changes and compromises. MSMA ultimately endorsed the package, as did the Missouri Association of Osteopathic Physicians and Surgeons and the Missouri Nurses Association. With its promise to improve access to basic health care, clear-up the legal uncertainty hanging over delegating physicians, and maintain the physician's role as the ultimate gatekeeper for providing patient care, the bill was passed.

As enacted, House Bill 564 prescribes that any delegation of authority under a collaborative practice agreement must be made pursuant to written standing orders and protocols, and cannot exceed the scope of practice of the nurse. A physician may delegate to an advanced practice nurse the authority to prescribe, administer, and dispense drugs, but the prescriptive authority does not extend to controlled substances.

Beyond that, the new statute contains little in the way of specifics. Regulations were needed to administer the details. Lawmakers authorized the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to promulgate joint rules to implement the new law.

The rule-making boards began meeting conjointly in the summer of 1993. They met countless times over the next 18 months, painstakingly hammering out rules to govern collaborative practice arrangements. Finally, in January of 1995, the proposed regulations were published. And they were not without controversy.

MSMA and other groups objected strenuously to several of the provisions. At MSMA's request, the boards held four public hearings across the state, affording all physicians the opportunity to comment. MSMA petitioned the General Assembly's Joint Committee on Administrative Rules to hear the matter. Following a 7-hour public hearing in June of 1995, that committee voted unanimously to suspend the proposed rules and sent the boards back to the drawing room.

This was a mixed blessing for medicine. On one hand MSMA believed the rules were dangerously flawed and worked hard to have the proposed rules suspended. On the other hand, in the absence of restrictive rules, even lax ones, the nurse practitioners were subject to very few limitations. Imperfect rules were better than no rules at all, and the rulemakers, who were by now some two years into the process, had just been dealt a major setback.

Continued on page 694

Collaborative Practice Rule Highlights

1. The Collaborative Practice arrangement must be in writing, and must be signed and dated.
2. Nurses shall not prescribe controlled substances.
3. The physician must be available for immediate consultation at all times, either in person or via telecommunications.
4. Nurse dispensing is limited to starter doses for up to 72 hours.
5. In primary care settings where an advanced practice nurse (APN) provides health care services including the diagnosis and initiation of treatment for acutely or chronically ill or injured persons:
    - A collaborating physician is limited to three "Full Time Equivalent" APNs.
    - The APN and the collaborating physician shall not be farther than 50 miles apart if that site is in a federally designated Health Professional Shortage Area (HPSA).
    - That limit is 30 miles in non-HPSAs.
    - The physician must be present "for sufficient periods of time, at least once every two weeks," to review and direct the provision of services.
    - The physician must see the patient "for evaluation and approve or formulate the plan of treatment for new or changed conditions" within two weeks after the patient has been seen by an APN.
    - The collaborating physician and the APN must practice together at the same location for at least one month before working at geographically separate sites.
    - The physician must review all medical records at least every two weeks, and must document that review.
6. In the well-patient setting where APN services are limited to immunizations, well child care, STD care, cancer screening, TB control, etc.:
    - There is no limit on the distance allowed between the physician and the APN.
    - Review of records must be done on an "as needed" basis.
    - Generally, no other limits.

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Further negotiations followed until October of 1995, when a new compromise was struck. That set of proposed rules was published on March 1, 1996. MSMA formally objected to several of the new provisions, but privately conceded that this package probably was as close to reasonable as politically possible at the time. One group appealed again to the Joint Committee on Administrative Rules, but the committee found no merit in their objections. The final rules were published on August 1, 1996, and they went into effect on September 1. They are reprinted in their entirety on pages 694-698.

Missouri physicians considering a collaborative practice arrangement should exercise care and forethought. Collaborative practice arrangements may dramatically enhance the delivery of health care services to your patients. But these are uncharted waters and they are to be entered with caution. Before venturing forth, you should ask yourself a few questions:

* Does my practice really need a collaborative practice arrangement?
* Will my patients truly benefit from such an arrangement?
* Can I fulfill the obligations imposed in the collaborative practice regulations?
* Who retains ultimate responsibility for patient care?
* Will entering into a collaborative practice agreement increase my medical malpractice liability?
* Is that liability more or less when practicing with an advanced practice nurse as opposed to a registered professional nurse?
* What is my liability exposure under multiple collaborative practice arrangements?
* Do I create a physician-patient relationship when the patient is seen only by my nurse (and I merely review the record)?
* Does the nurse with which I sign a collaborative practice agreement carry his/her own primary malpractice liability insurance coverage?
* Where is the malpractice liability if my nurse is operating pursuant to a collaborative practice agreement in a managed care gatekeeper arrangement?

The collaborative practice rules are new and there are few rulings, judgements, or interpretations to guide you. Read the rules very carefully, then discuss the issues with your nurses, your partners, and perhaps your attorney. Specific questions also can be submitted to the Missouri Board of Healing Arts.

The Boards of Healing Arts, Nursing, and Pharmacy will monitor the progress of these new rules, gauging the need for changes and reform. MSMA will be watching as well. MoMed

Division 150 - State Board of Registration for the Healing Arts
Chapter 5 - General Rules
Order of Rulemaking

4 CSR 150-5.100 Collaborative Practice

Purpose: This rule defines collaborative practice arrangement terms and delimits geographic areas; methods of treatment; review of services; and drug/ device dispensing or distribution pursuant to prescription.

(1) For the purpose of these rules, the following definitions shall apply:

(A) Advanced practice nurse - a registered professional nurse who is also an advanced practice nurse as defined in section 335.016 (2), RSMo.

(B) Collaborative practice arrangements - refers to written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of health care services.

(C) Registered professional nurse - a registered professional nurse as defined in section 335.016 (9), RSMo, who is not an advanced practice nurse.

(2) Geographic Areas

(A) The collaborating physician in a collaborative practice arrangement shall not be so geographically distanced from the collaborating registered professional nurse or advanced practice nurse as to create an impediment to effective collaboration in the delivery of health care services or the adequate review of those services.

(B) The use of a collaborative practice arrangement by an advanced practice nurse who provides health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons shall be limited to practice locations where the collaborating physician, or other physician designated in the collaborative practice arrangement, is no further than fifty (50) miles by road, using the most direct route available, from the collaborating advanced practice nurse if the advanced practice nurse is practicing in federally designated health professional shortage areas (HPSAs). Otherwise, in non HPSAs, the collaborating physician and collaborating advanced practice nurse shall practice within thirty (30) miles by road of one another. The provision of the above specified health care services pursuant to a collaborative practice arrangement shall be limited to only an advanced practice nurse.

(C) An advanced practice nurse who desires to enter into a collaborative practice arrangement to provide health care services that include the diagnosis and treatment of acutely or chronically ill or injured persons at a location where the collaborating physician is not continuously present shall practice at the same location with the collaborating physician for a period of at least one (1) calendar month before the collaborating advanced practice nurse practices at a location where the collaborating physician is not present. The provision of the above specified health care services pursuant to a collaborative practice arrangement shall be limited to only an advanced practice nurse.

(3) Methods of Treatment

(A) The methods of treatment and the authority to administer, dispense, or prescribe drugs delegated in a collaborative practice arrangement between a collaborating physician and collaborating registered professional nurse or advanced practice nurse shall be within the scope of practice of each professional and shall be consistent with each professional's skill, training, education, and competence.

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(B) The collaborating physician shall consider the level of skill, education, training, and competence of the collaborating registered professional nurse or advanced practice nurse and ensure that the delegated responsibilities contained in the collaborative practice arrangement are consistent with that level of skill, education, training, and competence.

(C) The methods of treatment and the authority to administer, dispense, or prescribe drugs delegated to the collaborating registered professional nurse or advanced practice nurse in a collaborative practice arrangement shall also be consistent with the scope of practice of the collaborating physician.

(D) Guidelines for consultation and referral to the collaborating physician or designated health care facility for services or emergency care that is beyond the education, training, competence, or scope of practice of the collaborating registered professional nurse or advanced practice nurse shall be established in the collaborative practice arrangement.

(E) The methods of treatment and authority to administer, dispense, or prescribe drugs delegated to the collaborating registered professional nurse or advanced practice nurse in a collaborative practice arrangement shall not be further delegated to any other person except that the individuals identified in sections 338.095 and 338.198, RSMo may communicate prescription drug orders to a pharmacist.

(F) The methods of treatment, including any authority to administer or dispense drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating registered professional nurse shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that shall describe a specific sequence of orders, steps, or procedures to be followed in providing patient care in specified clinical situations.

(G) The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating advanced practice nurse shall be delivered only pursuant to a written agreement, jointly agreed upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating advanced practice nurse.

(H) The collaborative practice arrangement between a collaborating physician and a collaborating registered professional nurse or advanced practice nurse shall be signed and dated by the collaborating physician and collaborating registered professional nurse or advanced practice nurse before it is implemented, signifying that both are aware of its content and agree to follow the terms of the collaborative practice arrangement. The collaborative practice arrangement and any subsequent notice of termination of the collaborative practice arrangement shall be in writing and shall be maintained by the collaborating professionals for a minimum of eight (8) years after termination of the collaborative practice arrangement. The collaborative practice arrangement shall be reviewed and revised as needed by the collaborating physician and collaborating registered professional nurse or advanced practice nurse.

(I) Methods of treatment delegated and authority to administer, dispense, or prescribe drugs shall be subject to the following:

1. The physician retains the responsibility for ensuring the appropriate administering, dispensing, prescribing and control of drugs utilized pursuant to a collaborative practice arrangement in accordance with all state and federal statutes, rules, or regulations;
2 All labeling requirements outlined in section 338.059, RSMo shall be followed;
3. Consumer product safety laws and Class B container standards shall be followed when packaging drugs for distribution;

4. All drugs shall be stored according to the United States Pharmacopeia (USP) recommended conditions;

5. Outdated drugs shall be separated from the active inventory;

6. Retrievable dispensing logs shall be maintained for all prescription drugs dispensed and shall include all information required by state and federal statutes, rules, or regulations;

7. All prescriptions shall conform to all applicable state and federal statutes, rules, or regulations and shall include the name, address, and telephone number of the collaborating physician and collaborating advanced practice nurse;

8. A registered professional nurse shall not, under any circumstances, prescribe drugs;

9. An advanced practice nurse shall not, under any circumstances, prescribe controlled substances. The administering or dispensing of a controlled substance by a registered professional nurse or advanced practice nurse in a collaborative practice arrangement shall be accomplished only under the direction and supervision of the collaborating physician, or other physician designated in the collaborative practice arrangement, and shall only occur on a case-by-case determination of the patient's needs following verbal consultation between the collaborating physician and collaborating registered professional nurse or advanced practice nurse. The required consultation and the physician's directions for the administering or dispensing of controlled substances shall be recorded in the patient's chart and in the appropriate dispensing log. These recordings shall be made by the collaborating registered professional nurse or advanced practice nurse and shall be co-signed by the collaborating physician following a review of the records;

10. An advanced practice nurse or registered professional nurse in a collaborative practice arrangement may only dispense starter doses of medication to cover a period of time for seventy-two (72) hours or less with the exception of Title X family planning providers or publicly funded clinics in community health settings that dispense medications free of charge. The dispensing of drug samples, as defined in 21 U.S.C. § 353 (c) (1), is permitted as appropriate to complete drug therapy; and

11. The medications to be administered, dispensed, or prescribed by a collaborating registered professional nurse or advanced practice nurse in a collaborative practice arrangement shall be consistent with the education, training, competence, and scopes of practice of the collaborating physician and collaborating registered professional nurse or advanced practice nurse.

(J) When a collaborative practice arrangement is utilized to provide health care services for conditions other than acute self-limited or well defined problems, the collaborating physician, or other physician designated in the collaborative practice arrangement, shall see the patient for evaluation and approve or formulate the plan of treatment for new or significantly changed conditions as soon as is practical, but in no case more than two (2) weeks after the patient has been seen by the collaborating advanced practice nurse. The provision of the above specified health care services pursuant to a collaborative practice arrangement shall be limited to only an advanced practice nurse.

(4) Review of Services

(A) In order to assure true collaborative practice and to foster effective communication and review of services, the collaborating physician, or other physician designated in the collaborative practice arrangement, shall be immediately available for consultation to the

Continued on page 698

Continued from page 697

collaborating registered professional nurse or advanced practice nurse at all times, either personally or via telecommunications.

(B) The collaborating physician shall review the work, records, and practice of the health care delivered pursuant to a collaborative practice arrangement at least once every two (2) weeks. This review shall be documented by the collaborating physician. This subsection shall not apply to the situation described in subsection (4) (E) below or during the time the collaborating physician and collaborating advanced practice nurse are practicing together as required in subsection (2) (C) above.

(C) If a collaborative practice arrangement is used in clinical situations where a collaborating advanced practice nurse provides health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons, then the collaborating physician shall be present for sufficient periods of time, at least once every two (2) weeks, except in extraordinary circumstances that shall be documented, to participate in such review and to provide necessary medical direction, medical services, consultations, and supervision of the health care staff. In such settings the use of a collaborative practice arrangement shall be limited to only an advanced practice nurse and the physician shall not enter into a collaborative practice arrangement with more than three (3) full time equivalent advanced practice nurses.

(D) The collaborating physician and collaborating registered professional nurse or advanced practice nurse shall determine an appropriate process of review and management of abnormal test results which shall be documented in the collaborative practice arrangement.

(E) In the case of collaborating physicians and collaborating registered professional nurses or advanced practice nurses practicing in settings which provide care to well patients or to those with narrowly circumscribed conditions in public health clinics or community health settings that provide population based health services limited to immunizations, well child care, HIV and sexually transmitted disease care, family planning, tuberculosis control, cancer and other chronic disease and wellness screenings, services related to epidemiologic investigations and prenatal care, review of services shall occur as needed and set forth in the collaborative practice arrangement. If the services provided in such settings include diagnosis and the initiation of treatment of any other disease or injury, then the provisions of subsection (4) (C) shall apply.

(F) The process and documentation of review shall be on file and maintained in the collaborative practice setting.

(G) The Missouri State Board of Registration for the Healing Arts and the Missouri State Board of Nursing separately retain the right and duty to discipline their respective licensees for violations of any state or federal statutes, rules, or regulations regardless of the licensee's participation in a collaborative practice arrangement.

(5) Population-Based Public Health Services

(A) In the case of the collaborating physicians and collaborating registered professional nurses or advanced practice nurses practicing in association with public health clinics that provide population-based health services limited to immunizations, well child care, HIV and sexually transmitted disease care, family planning, tuberculosis control, cancer and other chronic disease and wellness screenings, services related to epidemiologic investigations and related treatment, and prenatal care, the geographic areas, methods of treatment and review of services shall occur as set forth in the collaborative practice arrangement. If the services provided in such settings include diagnosis and initiation of treatment of disease or injury not related to population-based health services, then the provisions of sections (2), (3), and (4) above shall apply.

KC
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Annual Convention

APRIL 10 THRU 13, 1997
WESTIN CROWN CENTER

MISSOURI STATE MEDICAL ASSOCIATION

General Meetings & Events

MSMA members and guests are welcome to attend all **MSMA meetings and events**. Please join us for the following scheduled activities.

The Annual Convention is a good opportunity to meet your MSMA Officers, Councilors and Delegates. Take the time to get to know your leaders.

THURSDAY

Opening Session, MSMA House of Delegates
Thursday, April 10 10:00 a.m.

St. Louis Metropolitan Medical Society Luncheon and Caucus
Thursday, April 10 11:45 a.m.

Metropolitan Medical Society of Greater Kansas City Luncheon
Thursday, April 10 12:00 noon

Reception Honoring MSMA and MSMAA President
Thursday, April 10 6:00 p.m.

FRIDAY

Councilor Breakfast, Districts 1,2,5,6,8,10
Friday, April 11 7:00 a.m.

MU Alumni Organization Board of Governors' Breakfast Meeting
Friday, April 11 7:30 a.m.

MSMA General Session
Friday, April 11 9:00 a.m.-10:30 a.m.

Resident Physicians Section Meeting
Friday, April 11 10:30 a.m.

Young Physicians Section Meeting
Friday, April 11 10:30 a.m.

Discuss the Issues with your AMA Delegates
Friday, April 11 11:00 a.m.

Councilor Districts 7 and 9 Luncheons
Friday, April 11 12:00 noon

Student Delegates Luncheon & Business Meeting
Friday, April 11 12:00 noon

MU Alumni Awards Luncheon
Friday, April 11 12:30 p.m.

St. Louis Metropolitan Medical Society Caucus
Friday, April 11 2:00 p.m.

Second Session, MSMA House of Delegates
Friday, April 11 4:00 p.m.

Receptions for UMC, UMKC, St. Louis University and Washington University
Friday, April 11 6:00 p.m.

SATURDAY

Organized Medical Staff Section General Session
Saturday, April 12 10:00 a.m.-12:00 noon

MMPAC Meeting
Saturday, April 12 1:30 p.m.

MSMA General Session
Saturday, April 12 2:00 p.m.

MSMA Presidential Inauguration
Saturday, April 12 6:00 p.m.

MSMA Reception
Saturday, April 12 7:00 p.m.

SUNDAY

Final Session, MSMA House of Delegates
Sunday, April 13 7:30 a.m.

Information . . .
There are no tickets to purchase or fees required to attend the MSMA's General Meetings and Events.

Medical Specialty Events

Missouri State Allergy Association & Missouri Thoracic Society

Mark Vandewalker, MD, Program Chair
Jefferson City

Saturday, April 12

Breakfast	7:30 a.m.
Scientific Program	9:00-11:30 a.m.
Luncheon	11:30 a.m.-12:45 p.m.
Business Meeting	

. . . .

Missouri Society of Anesthesiologists

Michael Ritter, MD, Program Chair, St. Louis

The emergency airway is this year's topic. Our objective is to inform and educate the Missouri Society of Anesthesiologists' membership in the most recent research and techniques in maintaining the emergency airway. We will also examine recent technological advances which allow improved patient safety and care during difficult intubation.

In the evaluation forms from the previous year's scientific program, we asked the constituency to name topics for future programs that would be of interest. We then determined which of these requested topics would be of most interest and educational value to the group as a whole.

Friday, April 11

MSA House of Delegates First Session	4:00-5:00 p.m.
Reference Committee Meeting	6:00-7:30 p.m.
Reception	8:00-9:00 p.m.

Anesthesiologists continued...

Saturday, April 12

Breakfast	8:30 a.m.
Scientific Program	9:00-11:30 a.m.

Fiberoptic Intubation Techniques
Speaker: Joseph Tobias, MD
University of Missouri-Columbia

Alternatives to Routine Airway Management Crisis
Speaker: Carin Hagberg,MD
University of Texas

Luncheon	11:30 a.m.-12:45 p.m.
Scientific Program	1:00-2:00 p.m.

Cari Engler Memorial Lecture
The ASA Difficult Airway Algorithm
Speaker: Jonathan Benumof, MD
University of California, San Diego
(underwritten by Mallinckrodt Medical)

Moderator: Michael Ritter, MD

MSA House of Delegates Second Session	2:30-3:30 p.m.

If you would like to attend the luncheon and/or reception please RSVP at 573-636-6905. There will be a charge of $20 per function.

Membership Activity

During the Annual Convention, MSMA members will be encouraged to participate in a Peer Recruitment Effort.

More details will be forthcoming.

Christian Medical and Dental Society

Richard Heimburger, MD, Program Chair
Jefferson City

The objective is to present the Judeo-Christian viewpoint on socioeconomic, ethical and other relevant medical issues of the day. Participants are invited to share in this open forum discussion about how these needs and concerns affect the care and healing of our patients.

The procedure for determining which needs should be addressed was made by personal contact with members of the medical association, chaplains and hospital staff to determine ethical, socioeconomic and spiritual needs and concerns in our changing managed care environment. We need to know how these concerns affect the care of our patients.

Sunday, April 13

Scientific Program 9:30 a.m.
Current Problems in Medical Ethics

Missouri Dermatological Society

John DeSpain, MD, Program Chair, Columbia

Saturday, April 12

Scientific Program 9:00 a.m.
Dermatology for the non-Dermatologist

Missouri Academy of Family Physicians

Lawrence Rues, MD, Program Chair
Kansas City

The objectives of this program are to update the physician on the latest concepts in the pathophysiology of condyloma, present a rational approach to the management of the abnormal pap smear and to discuss the pros and cons of treatment modalities for condyloma.

Friday, April 11

Scientific Program 11:00 a.m.-12:30 p.m.

Contemporary Management of Condyloma
(The gynecologic and dermatologic aspects of condyloma)
Speaker: Steven Waggoner, MD
Chicago, IL
Moderator: Lawrence Rues, MD

Missouri Society of Internal Medicine

James Rogers, MD, Program Chair
Springfield

Saturday, April 12
Luncheon 11:00 a.m.-1:30 p.m.

American College of International Physicians

Kul Aggarwal, MD, Program Chair
Columbia

After attending this conference, participants will be able to update their knowledge on current practice of a wide variety of clinical problems and 1) understand the process involved in choosing the most appropriate anti-hypertensive agent for an individual patient, *International Physicians continued...*

2) apply the latest therapy in the treatment of obesity, 3) recognize and manage appropriately hypoglycemia occurring in diabetics while maintaining adequate control of hyperglycemia, 4) effectively manage the common problem of constipation in daily practice, 5) recognize, confirm and treat osteoporosis, 6) understand current principles of heart failure therapy and apply them to improve patient management.

Determination by the program planners based on new methods of diagnosis and treatment that would be of practical value to practicing physicians in their day-to-day management of common medical problems. Emphasis on methods which have significantly changed management of these conditions. Feedback from attendees of previous meetings as to their perceived needs and wishes to acquire further knowledge. This feedback was based on verbal comments and on written evaluations obtained from the attendees. Input from experts in various specialities as to recent advances within their fields of interest.

Saturday, April 12

Scientific Program 8:30 a.m.-12:05 p.m.

Which Anti-hypertensive agent? Rational Choice of Anti-hypertensive Therapy
Speakers: Jones Samuel, MD
Ramesh Khanna, MD
University of Missouri-Columbia

Obesity: A Big Problem! Advances in Management
Speaker: H. S. Sandhu, MD
University of Missouri-Columbia

Hypoglycemia: Managing the Lows While Aiming for Tight Control of the Highs in Diabetes Mellitus
Speaker: George Griffing, MD
University of Missouri-Columbia

Constipation: Managing the Obstinate Bowel
Speaker: Madhuri Trivedi, MD
University of Missouri-Columbia
Moderator: Amolak Singh, MD

Osteoporosis: Recognition and Diagnostic Techniques
Speaker: Amolak Singh, MD
University of Missouri-Columbia

Osteoporosis: What to Do About It?
Speaker: Sharad Goel, MD
University of Missouri-Columbia

Anemia in Childhood: Practical Considerations
Speaker: Jasleen Goel, MD
University of Missouri-Columbia

The Failing Heart: Management Principles in 1997
Speaker: Kul Aggarwal, MD
University of Missouri-Columbia
Moderator: Ramesh Khanna, MD

Missouri State Neurological Association

Joseph Hanaway, MD, Program Chair Columbia

Saturday, April 12

Scientific Program 10:00 a.m.

Missouri State Neurosurgical Society

David Jimenez, MD, Program Chair, Columbia

Saturday, April 12

Scientific Program 9:00 a.m.

Luncheon 12:00 noon

Missouri State Orthopaedic Association

Thomas Highland, MD, Program Chair
Columbia

Friday, April 11

Board Meeting	5:00-6:30 p.m.
Reception	6:30-8:00 p.m.

Saturday, April 12

Breakfast	7:00-8:00 a.m.
MSOA Program	8:30 a.m.-12:00 noon
Legislative Update	8:30-9:00 a.m.
Managed Care in the State of Missouri	9:00-9:30 a.m.
American Academy of Orthopaedic Surgery Board of Councilors Report	9:30-10:00 a.m.
Shadow an Orthopaedic Surgeon Program	10:00-10:30 a.m.
Symposium: State of Medicine, What It Means to You and What it Means in the State of Missouri	10:30 a.m.-12:00 noon

Managed Care:

Management Services Organizations (MSOs) and Managed Care in Missouri will be the topics of a panel discussion to be held during the Annual Convention. More details will be forthcoming.

Missouri Society of Otolaryngologists

Greg Renner, MD, Program Chair, Columbia

Saturday, April 12

Breakfast & Business Meeting	7:15 a.m.
Scientific Program	8:45 a.m.
Luncheon	12:15 p.m.

Missouri Society of Pathologists

Michael Caughron, MD, Program Chair
Kansas City

Saturday, April 12

Scientific Program	9:00 a.m.
Luncheon & Business Meeting	12:00 noon

Central Society of Physical Medicine and Rehabilitation

George Varghese, MD, Program Chair
Kansas City, KS

The objectives for these sessions are: 1) Review basic anatomy of the brachial plexus, 2) Discuss clinical features and E.M.G. findings in plexus injuries, 3) Learn conservative management of plexus injuries, 4) Review immediate surgical treatment and reconstructive surgery for brachial plexus injury, and 5) Discuss evaluation and management of the chronic pain patient from a physiatrist's point of view.

Topics were selected following a telephone survey of practicing physiatrists in Kansas City, Columbia and St. Louis. Brachial plexus injury is a topic of interest not only to rehabilitation medicine physicians, but also to physicians from other fields.

This will be a seminar format with different speakers on each topic. Participants will have time to ask questions at the end of each session.

Physical Medicine & Rehabilitation continued...

Speakers include one guest speaker and these will be from the field of Physical Medicine and Rehabilitation.

Saturday, April 12

Coffee Break	9:30-10:00 a.m.
Scientific Program	10:00-11:40 a.m.

Review of Anatomy of Brachial Plexus and E.M.G. Findings
Speaker: Atul Patel, MD
University of Kansas Medical Center

Conservative Management of Brachial Plexus Injuries
Speaker: Robert Conway, MD
University of Missouri-Columbia

Surgical Management of Acute Injury and Reconstructive Surgery
Speaker: Bruce Toby, MD
University of Kansas Medical Center

Moderator: George Varghese, MD

Luncheon	12:00-1:30 p.m.
Scientific Program	1:30-2:30 p.m.

Difficult Patient - Physiatric Approach
Speaker: Richard Katz, MD
St. Louis University

Resident Presentation	2:30-3:30 p.m.

Resident Paper Presentations
Speakers: Selected Papers

Moderator: Abna Ogle, MD

Information...

The Physical Medicine &Rehabilitation sessions will be of interest to: Physiatrists, Family Physicians, Obstetricians, Orthopaedic Surgeons, Neurosurgeons and Neurologists.

MSMA General Session

April 11, 9:00-10:30 a.m.

Mr. Steve Wetzell
Bloomington, MN

Steve Wetzell is the executive director of the Buyers Health Care Action Group (BHCAG), a coalition of 24 Twin City-based employers providing health care for 400,000 employees, retirees, and dependents throughout Minnesota, western Wisconsin and eastern North and South Dakota. Through their collective purchasing initiative, the member employers of the BHCAG are attempting to create a market driven by consumer choice of competing care systems. BHCAG member employers have developed a self-funded health plan featuring a common plan design, provider network and administrator. The plan has been offered since 1993.

Prior to joining BHCAG, Mr. Wetzel worked in human resource management for 14 years in the areas of compensation, benefits and labor relations. During 1990, he headed a project at Northern States Power Company to introduce managed care for more than 7,000 bargaining and non-bargaining employees. Mr. Wetzell joined the First Bank System in 1991, where he managed the occupation safety and health, retirement and welfare benefits and payroll functions. First Bank System implemented a national managed care plan for more than 8,500 employees in 8 states, implemented by First Bank System in 1992. He represented First Bank on the BHCAG board of directors.

Mr. Wetzell serves on the Board of Directors of the Minnesota State Health Care Data Institute and the National Business Coalition on Health. He is a member of the Board of Directors of the Institute for Clinical Systems Integration. He also serves as a fellow on Senator David Durenberger's Washington health care staff.

Missouri Association of Plastic and Reconstructive Surgeons

William Huffaker, MD, Program Chair, St. Louis

Friday, April 11

Scientific Program	2:30-4:00 p.m.

Saturday, April 12

Board of Directors' Breakfast and Meeting	7:00 a.m.
Scientific Program	9:00 a.m.
Luncheon & Business Meeting	12:00 noon

Missouri Radiological Society

Arlene Segal, MD, Program Chair, Kansas City

Saturday, April 12

Breakfast	8:00 a.m.
Board of Directors' Meeting	8:30 a.m.
Luncheon	12:30 p.m.
Scientific Program	1:30 p.m.
Annual Membership Meeting	3:30 p.m.

Missouri Chapter American College of Surgeons

Michael Bukstein, MD, Program Chair
Hannibal

This program is co-sponsored by: **Missouri State Surgical Society and American Cancer Society Heartland Division, Inc.**

Surgeons, continued...

The goal in selecting the subjects of Melanoma, colorectal cancer and sarcomas is to keep the medical field abreast of new techniques and procedures in the treatment of cancer. These subjects are of interest to the media and it is our intent to share up-to-date information to assist physicians in giving their patients the best treatment possible.

Subjects for presentations are determined by evaluation forms from the previous year and discussing topics with physicians from around the state of their needs.

Saturday, April 12

Breakfast	8:30 a.m.

Scientific Program

Discussion of Melanoma 9:00-10:30 a.m.
Speaker: William G. Kraybill, MD
State University of New York

Colorectal Cancer 10:30 a.m.-12:00 noon
Speaker: James Fleshman, MD
Barnes-Jewish-Christian

Luncheon	12:00 noon

Scientific Program

Update on Sarcomas
Speaker: William G. Kraybill, MD
State University of New York
Moderator: Michael Bukstein, MD

Information...
There is no charge to attend the luncheon with guest speaker. To register, please call Linda Wheelen at 417/869-5222, leave your name, address and phone number. If you should need to cancel, please advise as the seating is limited.

Missouri State Surgical Society

Ann Peick, MD, Program Chair, Poplar Bluff

The participant can expect to 1) review basic CPT and ICD-9-CM conventions, guidelines and coding rules, 2) sharpen CPT and ICD-9-CM coding skills to enhance reimbursement and reduce the number of denied and unpaid claims, 3) learn problem-solving methods for CPT and ICD-9-CM coding questions through coding exercises and discussions, and 4) identify resources for help in solving future coding problems.

Friday, April 11

Scientific Program 11:00 a.m.-12:30 p.m.
Coding for the General Surgeon

Scientific Program 1:30-3:00 p.m.
Managed Care for General Surgeons: Meeting the Challenge and Taking Charge

Information...
Please see the programs sponsored by the Missouri Chapter American College of Surgeons, Missouri State Surgical Society and the American Cancer Society Heartland Division, Inc.

American Medical Women's Association

Suzanne L. Miller, MD, Program Chair
Wildwood

Saturday, April 12

Scientific Program 10:30 a.m.
Neuromythology of Attention Deficit Disorder: Fact or Fiction

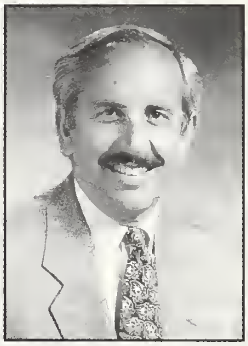
Pharmacology of Attention Disorder in Children and Adults

Luncheon & Business Meeting 12:00 noon

Overview of the Economic Role of Women Physicians in America - 1996

Organized Medical Staff Section General Session

April 12, 10:00 a.m. - 12:00 noon



Joseph Green, PhD
San Diego, CA

Dr. Green has served as Director of Continuing Medical Education and Vice President of Medical Education for Sharp HealthCare, an integrated health care system in San Diego, CA since 1989. He is also president of Professional Resource Network, Inc., a consulting firm which has provided assistance to several national specialty societies, medical schools, voluntary associations, and hospitals. He has been a Clinical Assistant Professor of Medical Education at the University of Southern California School of Medicine between 1982 and 1994 and Clinical Associate Professor since 1994.

Robert Pyatt, Jr., MD
Chambersburg, PA

Dr. Pyatt is serving as the acting Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians. He has been serving for the past four years, as an ACCME national surveyor. Dr. Pyatt has been selected to serve on the Board of Examiners with the 1996 Malcolm Baldridge National Quality Award; only a few physicians in the United States are selected for this honor, and he is the first member of the CME community who has achieved this status.

General Information

Missouri State Medical Association's 1997 Annual Convention to be held April 10-13, 1997 at Westin Crown, Kansas City.

This Annual Convention will feature numerous activities and scientific programs in addition to the MSMA Alliance events. This is an excellent opportunity for you to receive Continuing Medical Education.

Continuing Medical Education . . .
The Missouri State Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor Continuing Medical Education activities.

The Missouri State Medical Association designates the Continuing Medical Education offerings as Category 1 or Category 2 of the Physician's Recognition Award of the American Medical Association.

Hotel Reservations . . .
The hotel reservation form has been provided for your convenience in making your hotel accommodations. ***Hotel reservations must be made prior to March 1, 1997.***

1997 Convention Deadlines

Citizenship and Community Service Awards
Nominations should be submitted in writing to the MSMA office or through a local component medical society. **January 22, 1997.**

Resolutions for Delegate's Handbook:
Resolutions may be submitted by individuals, component medical societies or groups of physicians. **February 24, 1997.**

Members for the House of Delegates:
Component Societies should be preparing to send Delegates to the House. Each society will be notified as to the number of delegates they can send.

Information...

If you have information to include in the official program of the Missouri State Medical Association's 1997 Annual Convention, please call Mr. Ron Ellison 573/636-5151.

MSMA Preregistration

The 1997 Annual Convention offers a large variety of educational activities. To assist you in attending these programs, we ask that you complete and return this convenient preregistration form.

Upon receipt of your preregistration form, we will send your confirmation card which you will need to present at the Convention registration desk. Your registration packet and name badge will be awaiting your arrival.

Please return to MSMA,113 Madison Street
PO Box 1028, Jefferson City, MO 65102.
FAX: 573/636-8552

____
Name

____
Mailing Address

____
City/State/Zip

____
Component Medical Society

☐ Delegate ☐ Member

Hotel Reservation

The Westin Crown Center Guest Room Reservations must be received by March 1, 1997.

Name ______________________________

Firm/Company ______ Missouri State Medical Association ______________

Address ______________________________

City/State/Zip ______________________________

Phone ______________________________

Arrival Date: ______________ Time of Arrival: ____________ Departure Date: ______________

What major credit card will be used for payment upon check-out?

Card Type: ______________ Number: ______________ Expiration Date ______________

To confirm your reservations we accept only one of the following as means of payment:
One Night's Deposit (Enclosed), American Express, Visa, Mastercard, Diner's Club.

Reservation requests must be received no later than March 1, 1997
to guarantee accommodations.
However, reservations may be accepted and confirmed up to the opening day of the Convention providing accommodations are still available and the group rate is not guaranteed.
Reservations are 4:00 p.m. the day of arrival until 12:00 noon the day of departure.

Requested Room Type

☐ SINGLE (one person), $99.00

☐ DOUBLE (two persons) with one king size bed on request, $99.00

☐ TWIN (two persons) with two double beds, $99.00

☐ SUITES (1&2 bedroom) rates available from hotel

For Your Information . . .

Deposit refundable if reservation is cancelled 48 hours prior to arrival
(call toll free 1-800-228-3000 or 816-474-4400).
If rate requested is not available, nearest available rate will be assigned.
Rates do not include tax. Billing arrangements must be made at least two weeks before arrival. Please contact credit manager 816-474-4400 Ext. 2484.

Return form & deposit to:
The Westin Crown Center, One Pershing Road, Kansas City, Missouri 64108
Attention: Reservation Department

Missouri State Medical Association Alliance Annual Meeting

Thursday, April 10

Registration & Information	8:00 a.m.-4:00 p.m.
Past Presidents' Luncheon	11:30 a.m.
Pre-Convention Board Meeting	2:00 p.m.
President's Reception	6:00-7:00 p.m.
An Elegant Evening at *The Carriage Club*	7:30 p.m.

Friday, April 11

Registration & Information	8:00 a.m.-4:00 p.m.
General Assembly Opening Session	8:30 a.m.-12:00 noon
All-Star Awards Luncheon	12:00 noon

Friday, continued...

Informal Fashion Modeling by Halls Department Store, Crown Center (A $25 gift certificate from Halls will be given to all attendees.)	
AMA-ERF Benefit *Stardust, Tophats and All That Jazz!*	7:30 p.m.

Saturday, April 12

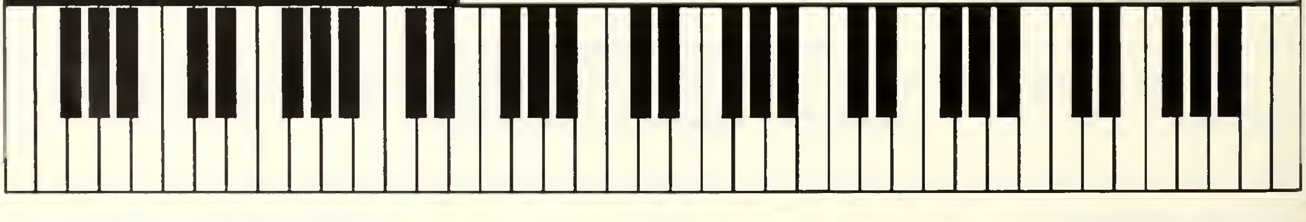
Registration & Information	8:00 a.m.
General Assembly Second Session	8:30 a.m.-12:00 noon
Installation Luncheon	12:00 noon
Post-Convention Board Meeting	2:00 p.m.
MSMA Presidential Installation and Presidents' Reception	6:00 p.m.

Friday, April 11
7:30 p.m.

AMA-ERF Benefit

Dinner Auction
Artwork donated by Missouri physicians and their families
Music for listening and dancing by the Don Cox Jazz Band

Stardust, Tophats and All That Jazz!



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The Benefits of a Paperless Medical Practice

James E. Palen, MD - Cape Girardeau

The first software programs for computerizing patient medical charts entered the marketplace more than a decade ago, and they were, in retrospect, a primitive lot. Today, advances in technology have yielded more powerful, more versatile products that make it easier and more advantageous to computerize patient charts.

The space and time-saving advantages of converting to or starting a new practice with a paperless chart system are clear to anyone familiar with computer technology. The big questions for physicians are cost (paper vs. no paper) and how it will actually work in the practice.

In my family practice in Cape Girardeau we have spent years exploring these issues. Since 1985, my medical office has used PAL/MED, a combination billing, claims filing and medical records package that I developed and continue to revise with my son Rick, a computer programmer, to reflect advances in computer technology. I have also helped many other practitioners, including a number in Missouri, implement the system, and I follow developments in the field closely. I would like to share my experiences of having a paperless medical practice.

General Benefits

In general, medical records software presents the patient's medical record in an organized format that encompasses medical histories, patient care and nursing notes, immunization records and lab and X-ray reports. Many practices use these programs to supplement their paper charts, but an increasing number are using them to create offices that are nearly paperless.

The best programs of the breed address three critical needs in today's health care environment: increased physician efficiency, cost savings and improved patient care. With PAL/MED, for example, we estimate that the average physician can save at least one hour of personal administrative time daily. Dictation is practically eliminated because data is entered directly into the computer record during or immediately after the exam. Prescriptions, consultation letters, orders, and printed history and physical exams can be generated directly from the electronic input made to the chart. A patient's blood pressure history, old EKGs or other needed data can be accessed with a few keystrokes.

With the time saved, programs like PAL/MED make it possible to devote more time to individual patients and/or to see and treat more patients. They also help minimize the risk of therapeutic error because they provide information such as automatic drug interaction warnings and contraindications. A good program also generates patient care advice and instructions, and provides an automatic patient recall system that helps ensure proper follow up.

For a guide to what to look for in medical records software, consult *Family Practice Management* (1996:3:35-49), which ranked PAL/MED as one of the most comprehensive and sophisticated electronic medical records packages available. PAL/MED was also recently selected as IBM's medical-records package of choice.

Cost Advantages

The price of implementing an electronic medical records system depends on the size of your practice. For a solo practice, the cost usually will be between $35,000 and $45,000, including software and hardware; for a five-doctor office, $80,000 to $100,000.

But when you factor in the costs of NOT computerizing, you come out ahead. You get your investment back in savings on office space, chart racks, storage costs and personnel time. In some practices, for example, high-priced staff members spend a considerable portion of their time doing chart-related clerical tasks such as making sure that patient charts are in the right place at the right time. If the nursing staff spends a total of two hours a day in these activities, the cost to the practice is about $15,000 per year. In addition, these non-productive hours are lost to providing patient-oriented services which could generate additional billing.

According to our estimates, an average two-doctor practice can save more than $2,000 per month by converting to computerized charts. Of this amount, roughly $600 reflects the savings in storage space, and a staggering $1,500 reflects staff time spent in clerical endeavors such as pulling and refiling paper charts and placing notes in the charts. The cost of the extra computerware needed to implement electronic medical records is negligible when weighed against these ongoing expenses and amortized over the life of the system. (See chart)

A Day in the Office

This is how PAL/MED computerized medical charts affect my practice's daily routine:

The day begins with my receptionist and transcriptionist, Beth Eichorn, booting up the computer at the nursing station. This is a UNIX machine with a Pentium processor (100 MHZ), a 1.6 gigabyte hard disk and a built-in tape drive for data back-up. Eichorn first gets a report that the previous day's back-up was performed satisfactorily and sends the tape to an off-site storage facility.

Next she turns to the scheduler, clicks on her appointment scheduler window and prints two copies of the schedule – one for herself and the other for the office nurse, Sherry Hart. Then, for each patient, she prints a one-page SOAP sheet that includes salient medical history and the latest SOAP notes. The SOAP sheet contains space for progress notes, dictation boxes for standard portions of the medical record (blood pressure, CV, GU, etc.), and space to write longer notes on abnormal findings.

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Cost of Paper vs. Electronic Medical Record

Estimates:

Two doctor practice with a patient population of about 10,000 patients and about 1250 patient visits each month. Of these patients, 7% (or 87) are new patient visits. Each new note requires an additional sheet of paper. There are 3500 charts stored in each 12 x 12 room.

The cost of paper charts	**Monthly Expenses**
Chart Folders ($1.20/chart)	105.00
Paper (4 sheets per new chart, $11.00 per 500 sheets)	
New Charts	7.00
Notes	8.33
Chart Rack ($695/500 charts)	121.63
Storage space (325 ft.^{2})	600.00
Cost of Personnel (pulling and refilling charts: 2 min. per move, one mis-file per 50 chart moves at 5 min. each, building an initial chart requires 10 min., placing a note in a chart requires 2.5 min., personnel cost is $12.00/hr)	
Pulling-Refilling	959.10
Building Initial Chart	175.00
Placing Notes in Charts	606.25
TOTAL	$2,582.91

Clearly the major contributing factors to the cost of paper charts are office space and personnel.

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Hart uses the SOAP sheet to do the initial patient work up, complaints, vitals and brief exam. She also determines whether medications need to be refilled. If so, she brings up the medical screen which prints refills directly on to Rx pads for my approval. Once in the exam room, I work with the SOAP sheet, so I have all the basic information I need on a single page and do not have to spend time rummaging through a thick paper chart. I place check marks in boxes for normal findings and note abnormal findings separately along with any other assessments and plans of action.

When I complete an exam, Hart retrieves the clipboard from the exam room door and either dismisses the patient, placing the SOAP sheet in the transaction box, or executes the plan, such as scheduling a test, writing an electronic Rx (which is automatically cross-checked for drug reactions) or ordering an EKG.

When there is a phone encounter with a patient, the record is brought up immediately at the station rather than having to locate a chart in the file room. A nursing note can be placed directly in the chart.

When X-rays, EKGs or other lab results are received, Hart scans them directly into the record using a flatbed scanner at her workstation. I can retrieve any report from the program at any time from the workstation I keep on my office desk.

If I am making hospital rounds, the staff prints a hospital list from the program, complete with diagnosis, consulting/referring physician, reminder notes, etc.

The dictation savings has been dramatic because data can be entered very quickly, often with one keystroke. In addition to the hour I save in dictation time each day, overall transcription time has been cut by 80%. The system also generates easy-to-use reports when patients need to be admitted to the hospital that can be faxed or modem transferred. An electronic tickler file helps to recall patients for necessary follow up visits or yearly exams. Patient instruction sheets are also easily printed for wound care, cast-care, special diets, etc.

Cost of Paper vs. Electronic Medical Record

Two doctor practice with a patient population of about 10,000 patients and about 1250 patient visits each month. Of these patients, 7% (or 87) are new patient visits. Each new note is entered directly into the EMR. There are no paper charts. A SOAP Sheet™ is used to interact between the doctor and the computer record. The practice already has a computer for its billing functions. All computer software and equipment amortized over 5 years.

Cost of Computerized Medical Record	Monthly Expenses
Additional computer hard disk and RAM	$0.08
Additional terminals for doctors and nursing staff	93.33
Additional printers and document scanner	25.00
Cost of printing SOAP Sheet™ for each patient	27.00
Cost of EMR software	133.33
Support service for EMR software	100.00
Cost of personnel (printing SOAP Sheet™ for each patient [5 min. batch per day - five additional walk-ins per day at 1 min. each]. No difference in cost of dictation service. Notes typed directly into the EMR)	
Printing	43.00
TOTAL	421.74

Fringe Benefits

The daily routine can vary to accommodate each practitioner's habits and the special needs of his or her individual specialty. The advantages can also change with the circumstances. One urgent care center in Florida that computerized its medical charts, for example, not only solved a critical

Continued on page 719

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Health Care Development as a Maturing Industry, Part II

Timothy McIntire, MD, MBA

As part of the natural evolutionary process, many industries pass through periods of rapid, chaotic change to a more controlled, modest change. This controlled, modest change signals a transformation from an emerging industry to a maturing industry. Industry maturity does not always occur at one certain time in an industry's growth, but when it does occur it is usually at a critical period in the industry's evolution. Industry maturation is a period of fundamental change during a company's life when its competitive environment reacts to the events which were part of its emerging challenges. The maturation period requires difficult strategic responses. Companies sometimes have trouble perceiving these environmental changes clearly and they may need strength to be flexible in their strategies to navigate the changes.

Characteristics of Industry Maturation

A maturing industry often experiences many changes different than the explosive growth and boundless potential of emerging industries. First, maturing industries see a slowing in growth which leads to more competition to control market share. Emerging industries acquire new market share by expanding into new areas of interest. Mature industries, competing in established areas of interest, capture new market share at the expense of their competitors. The knowledge one obtained during the emerging phase about their competitor's characteristics and reactions must be reassessed. During the maturation phase competitors are likely to be more aggressive and retaliate with cuts in prices, and by creating new levels of service and promotional or informational campaigns. For example health care providers who miscalculated the wave of managed care have been known to sign contracts well below the current market's fee schedules in an effort to recapture business they once had. These late entries, competing on price, play to the strength of HMOs in leveraging physicians against each other. The free market system at work?!?

Second, maturing industries are often contending with experienced, educated buyers. Because employers and HMOs know they can easily get discounts from physicians and hospitals, they now look to physician or hospital panel size, panel diversity, utilization data, etc., to award business. The buyers' focus shifts from deciding whether to purchase the PPO or HMO at all, to making choices among competing plans. Providers must learn to differentiate their services from other providers and to educate health purchasers on these differences in an effort to recapture an advantage.

Third, because the total market expansion is slowing, and the purchasers of health care are better educated, competition in this mature industry shifts towards greater emphasis on cost and service to both the employers who purchase the health services and the patients who receive the health services. Many hospitals and physicians must reorganize and re-engineer their businesses to achieve the new cost structure needed to be competitive. Investment in utilization management, information systems, physician extenders, professional management and physician leadership is only a beginning. The successful providers will meld these investments into a strategy which differentiates them from the competition on quality and outcomes. However, since quality and outcomes will only be measured in the most developed of information systems, many providers will be differentiated by the perception of quality and outcomes their investments build.

Fourth, as the growing health care industry continues to mature, it realizes the oversupply in and duplication of facilities, technology and even some physician specialties. Consolidation of these previously rapidly growing resources is the natural outcome of health care industry maturation. Hospitals will decrease the number of beds, merge, consolidate, and even close, in an effort to manage an unsustainable cost structure. No longer can the mistakes made in a rapid growth phase be hidden by the excess capacity in a cost-plus or fee-for-service industry. The purchasers (employers) are demanding the same or better quality of health care and technology at a lower total price, and many times they are successful in this goal. There will come a time when the excesses in our local health care delivery system have been eliminated, but for now, the economics of consolidation, utilization management, and cost containment will continue to play a major role in our professional lives.

Many of the changes we now are experiencing in Missouri concerning health care and managed care are similar to the 1980s changes seen in Minnesota and on the West Coast. The changes in Missouri parallel the basic managed care principles learned in these other states, but they evolve at a much faster pace. Our urban areas were the first to be penetrated, and then became footholds for the HMOs. As time and Medicare HMOs evolve, even the most rural of counties will not be spared some managed care influence. The remainder of this discussion is devoted to a description of how changes have occurred to force the rapid maturation of the health delivery system both on a national and a state level.

The Economic Chain

"The Economic Chain" is a concept researched by a Washington DC health care think tank named The Advisory Board Company. "The Economic Chain" refers to a sequence of events that is initiated by increasing buyer sensitivity to the price of health care, and the consequent changes these sensitivities stir throughout the industry. As the health care industry matures, "The Economic Chain" theory becomes more dominant, affecting the business of medicine as we know it.

As background to "The Economic Chain" theory, one notes that managed care has rapidly progressed over the past decade from a phenomenon seen mostly in selected states to the dominant form of health insurance on the commercial employer market. Even Medicare and Medicaid are making rapid entries into the managed care market. In 1995, 65% of the commercial health insurance market was served by managed care. The for-profit insurance companies have been the big winners in this evolution. In 1995, the for-profit companies controlled 55% of the commercial business, and they will continue to rapidly increase market share as we approach the year 2000. More aggressive marketing, better cost control, and lower prices have yielded 25% total enrollment growth per year over 10 years for the for-profits – versus just 2% growth per year for the not-for-profits. To understand why these trends have occurred, we will dissect the inner workings of "The Economic Chain" theory.

The first link in the chain is forged by employers and employees, the ultimate consumers of health care. As employers seek to reduce the cost of health care benefits, they search the health care market for a low-cost alternative to the traditional indemnity plans. The last decade offered managed care the opportunity to enter into the Missouri urban areas, and the rural areas will follow over the next decade. Employees will be encouraged to switch, over time, to less expensive PPOs, and then even lesser expensive HMOs offering incentives of lower monthly premiums, lower copays and deductibles and additional (previously non-covered) preventive care services. Insurers, forced to deal with a maturing market demanding cheaper premiums, are faced with falling per unit revenues. This creates an incentive for insurers to control administrative and operating expenses more aggressively and to reduce medical costs

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overall. It is at this stage that physicians begin to feel the effects of these evolving market realities.

In the early phases of the mature health care market, insurers search for cost savings by forcing changes in physicians' business and practice patterns. Reimbursement by CPT code falls and new methods of utilization review are implemented. Because efficient cost savings are rarely achieved even in deeply discounted fee-for-service arrangements, more mature markets have insurers implementing capitation payments to physicians. Capitation shifts the financial risk for the cost of care from the insurer to the physician. Because the physician often drives much of the costs in the health care delivery system, capitation risk is felt to give the physician the financial incentive to provide the best, most cost efficient care. As the health care industry matures and market forces drive a migration of patients into managed care plans, the health care industry will demand and the force of economics will compel a need to manage costs. This management of health care costs will then change the primary type of reimbursement from fee-for-service to various forms of capitation. The result of this industry maturation will be an end to unlimited choice, volume-based reimbursement and unlimited clinical autonomy. These will be replaced by a new era of medicine characterized by more restrictive choice, population-based reimbursement and clinical standardization. As this occurs we will be approaching the goal of cost containment, and the health care industry will be functioning in the mature phase of industry growth.

State and Local Implications

Here in Missouri we have seen five major areas which signify characteristics of a maturing health care industry.

The Success of Employer Coalitions.

Historically, insurers have benefited from "price blindness" among employers. However, in the past few years several of the state's major employers have formed coalitions to purchase health care which has eliminated this "blindness." State government has facilitated this process by both forming its own purchasing cooperative as well as collecting hospital pricing information to use as bargaining leverage. The result is lower insurance premium levels.

Elasticity of Choice.

While patients usually indicate they want to choose their own physician, most surveys and experiences show that choice is a decisive factor only when the price between plans is relatively close. The majority of patients are price sensitive and are willing to forgo free choice in exchange for comparatively small additional cost savings. This point has been emphasized in the Missouri Consolidated Health Care Plan where many state employees have joined gatekeeper HMOs and saved $200 to $500 per year in employee premiums.

Managing Costs Through Channeling.

Channeling, or diverting patient referrals to the most cost-efficient providers, is one of many cost reduction strategies which HMOs use. In addition, further cost savings are obtained by negotiating deeply discounted fees in exchange for patient volume. Early on channeling occurs to physicians and hospitals who are managed care friendly and proactive. As the markets mature, all providers are forced to participate, and plans then thin their provider networks to include only those who meet threshold cost standards.

Reverse Incentives Via Capitation.

Capitation is an increasingly common payment mechanism in maturing markets. Volume-based reimbursements, such as fee-for-service plans, can encourage overutilization. Forcing providers to pay for actual costs of care out of a fixed sum of prepaid dollars forces cost discipline by physicians and hospitals. While capitation can be quite emotional and controversial in local markets, if physicians rely on and supervise systems of efficient utilization management, capitation can be a mechanism to increase provider reimbursement in an otherwise declining reimbursement era.

Adverse Selection in Indemnity Insurance.

As the health care industry matures, healthier individuals tend to choose new, less costly managed care plans, leaving indemnity insurance companies with the downside of an adverse selection problem. This sicker population drives up the per unit costs of the indemnity plans, thus slowly driving indemnity options out of the market. As less and less indemnity plans are available, more employees are channeled into managed care options. Because indemnity insurers must compete with cost-controlled, for-profit managed care plans, this adverse selection causes an indemnity death spiral.

In conclusion, if physicians can understand the basic fundamentals of both emerging and maturing industries, and if they can apply those fundamentals to the health care industry, physicians should be able to understand and navigate the changes we are currently experiencing in our local health care markets. Rural physicians possess an advantage in that they can study the managed care impact of the major cities in Missouri, then prepare for the managed care influences which are slowly, but persistently coming to a hometown near you. **MoMed**

References

Competitive Strategy, Michael Porter

Medical Leadership Council Readings, The Advisory Board Company

The Author

Dr. McIntire is a partner with Boyce and Bynum Pathology Laboratories in Columbia and a Managed Care consultant for the Jefferson City Medical Group.

PAPERLESS MEDICAL PRACTICE

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space problem but also speeded up its reimbursement time for workers compensation claims by a factor of two or three because patients' medical records are now faxed by computer directly to the workers compensation carrier. This, in turn, has improved the clinic's cash flow.

For new practices, there are other fringe benefits. No one would consider starting a practice without a computer for managing accounts receivable, filing insurance and so on. The same office computer, if chosen well, can meet this and medical records needs. The small additional cost of a larger hard disk, additional RAM and additional terminals will be more than offset by the savings in office space, personnel time, chart racks and storage costs.

This is not to say that implementation is painless, either for new practices or established ones. There is always a learning curve, especially for new staff, and the first three or four months can be expected to be frustrating at times. There will certainly be adjustments for everyone, including the doctor.

But a well-designed electronic medical records program can be the glue that holds the practice together. It helps the staff coordinate their tasks so that patients get the optimum care and all of the required tasks are accomplished efficiently. It saves space and time. In today's increasingly digital era, it is really the only solution that makes sense. **MoMed**

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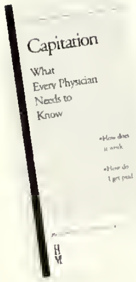

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1. Galata JF, Blue JM, Gaines RW. Osteochondroma of the scapula. *Missouri Medicine* 1995;92:95-97.

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Resolution Action Summary from the 1996 Annual Convention

Res. #	Subject	House Action	Council Action	Current Status
1	Pharmacist's Patient Education	Substitute Resolution #1 & #2 Adopted	Referred to Commission on Continuing Education & Health Manpower	The Commission is providin assistance in the development guidelines.
2	Drug Side Effects	See Resolution #1	See Above	See Above
3	Statewide Credential VerificationService as a New Member Benefit	Substitute Resolution Adopted	Referred to Commission on Medical Economics, Third Party Medicine & Governmental Relations	A request for proposal has be sent to credential verificatio organziations.
4	Plastic ID Cards for Managed Care Patients	Substitute Resolution Adopted	Referred to Commission on Medical Economics, Third Party Medicine & Governmental Relations	The Commission is addressin
5	MSMA- Sponsored Managed Care Organization	Substitute Resolution Adopted	Committee to Study Statewide Managed Care Organization	Published in ***Missouri Medici*** July 1996.
7	Proposed Constitution & Bylaw Changes	(1) Change Bylaw sections that refer to "Hospital Medical Staff Section" to "Organized Medical Staff Section"; (2) Add a section to Bylaws on affiliate members (3) Referred to MSMA Council the sections on "direct members"	Adopted Bylaw changes. Proposed Constitutional changes lay over until 1997 Annual Convention	Published in ***Missouri Medici*** 1996-97 Membership Directo
9	Aid to Republic of Georgia	Substitute Resolution Adopted	Publicize; inform Boone County	Publish in ***Progress Notes*** w updates of activity; letter to Co ponent Societies announcing eff press release to media outlets

HIV Testing Without the Right of Refusal	Substitute Resolution Adopted	Referred to Legislative Committee; sent to AMA	MSMA may introduce legislation to allow physicians to perform HIV testing without the patient's consent. Until that time, MSMA will support similar legislation that is introduced.
Inappropriate Antibiotic Use	Substitute Resolution Adopted	Referred to Commission on Public Affairs	Resolution title changed to "Appropriate Antibiotic Use"; research Dept. of Health; publicize in ***Progress Notes, Missouri Medicine***,component society publishing and events; researching informational pamphlets for publishing public health issues.
Statewide Information Network	Substitute Resolution Adopted	Referred to Commission on Continuing Education & Health Manpower	MoMed Net, MSMA's Internet Program, is being implemented throughout Missouri.
Regulation of Tobacco	Adopted	Referred to Committee on Legislative Affairs	MSMA is actively supporting anti-tobacco efforts.
Standardizing Claims Processing Methodology	Referred to Council	Referred to Commission on Medical Economics, Third Party Medicine & Governmental Relations	The Commission is addressing
HIV Testing in Pregnant Women	Substitute Resolution Adopted	Referred to Committee on Legislative Affairs	Staff is working with Dept. of Health developing HIV routine screening voluntary guidelines for pregnant women.
Essential Community Provider Legislation	Referred to Council	Referred to Committee on Legislative Affairs	Staff has contacted sponsors of the Essential Community Provider bill, communicated concerns from 1996 legislation, and asked for an opportunity to work together.
Gag Clauses in Health Plans	Amended Resolution Adopted	Referred to Committee on Legislative Affairs	Staff will continue to lobby the Joint Interim Committee on Managed Care to ensure strong anti-gag clause language is included in that committee's package of proposed managed care legislation.
Conversion of Missouri's Blue Cross & Blue Shield Plans from Not-for-Profit to For-Profit Status	Amended Resolution Adopted	Referred to Committee on Legislative Affairs	Review any legislation offered relating to Blue Cross/Blue Shield restructuring and determine, on an individual basis, which warrant support.

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The MSMA provides a democratic forum where you, along with your colleagues from across the state, can raise and debate issues, reach a consensus and formulate policy. MSMA policy is then translated into practical actions on issues that affect you and your practice.

Making sure medicine stays active, strong and united; It's one good reason you should GET INVOLVED with the MSMA.

In 1995 alone, the MSMA monitored over 1,300 legislative bills for their impact on physicians' practices and patients' health. The MSMA sponsored the Patient Fairness Act which would restore and preserve clinical autonomy by requiring due process and other important legal rights for physicians in managed care organizations.

Consistently advocating for Missouri's physicians; It's one more good reason you should GET INVOLVED with the MSMA.

The MSMA and your local medical society provide powerful advocacy for physicians and patients alike. While the MSMA represents you and your patients in Jefferson City, your local society works on your behalf with the local media and other entities.

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Working and winning on behalf of Missouri's physicians, the MSMA is here for you every day with the finest professionals working to assist you with today's challenges.

TO JOIN, complete the form provided on the next page and fax or mail it to:

Membership Department, MSMA
113 Madison Street, P.O. Box 1028
Jefferson City, Missouri, 65102
Fax (573) 636-8552, or call (573) 636-5151

MISSOURI STATE MEDICAL ASSOCIATION

Issouri State Medical Association

113 Madison ▸ P.O. Box 1028 ▸ Jefferson City, MO 65102
Tel: 573-636-5151 ▸ Fax: 573-636-8552

APPLICATION FOR MEMBERSHIP

e______________19_____

the Officers and Members of the ____ Component Medical Society:

reby apply for membership as ____Active Member ____2nd Year Practice ____1st Year Practice ____Resident Member (Completion Date:__________)

BIOGRAPHICAL INFORMATION

Name	First	Middle Initial	Suffix

eck Preferred Mailing Address: ____Home ____Office   Check Gender: ____Male ____Female

e of Birth	City/State/County	Spouse's Name, If Applicable
ce Address	City/State/Zip	County
ne	Fax	E-Mail
me Address	City/State/Zip	County
ne	Fax	E-Mail

EDUCATION

dical School	City/State/Country	Degree	Graduation Date (Mo/Yr)
ning - Full Name of Institution	City/State/Country		From (Mo/Yr) - To (Mo/Yr)
ning - Full Name of Institution	City/State/Country		From (Mo/Yr) - To (Mo/Yr)

LICENSING

al Number of Missouri License	Date Issued

ical Specialty(s)

d Certification(s)

procity with (Name State)	Date Issued

se List Site of Previous Practice:

ation/Title	From (Mo/Yr) - To (Mo/Yr)

your application for membership in any medical society ever been disapproved or have you even been suspended or expelled from membership in any medical society or has medical license ever been suspended or revoked? ____ *Yes* ____ *No* *If yes, please set forth details in a separate letter.*

icant Signature	Date

e print name

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applicant has been approved by the local medical society.

ponent Society Officer Signature	Date

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CME Calendar

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for free listing in *Missouri Medicine*.

NOVEMBER

13 thru 15 - *St. Louis*: Dimensions of a Disease. The Tenth Annual Symposium on HIV. 7 credit hrs. Call Susan Wightman 314-362-2418.
15 - *St. Louis*: Fat. Call Washington University 314-362-6891.
15 & 16 - *St. Louis*: Neurosurgical Endoscopy. 14 credit hrs. Call Practical Anatomy Workshop 314-535-4000.
15 &16 - *St. Louis*: Psychological Challenges in Woman's Life. Call 1-800-553-2712.
18 - *St. Louis*: The Thomas F. Maher Lecture in Radiology. Call 314-569-6290.
20 thru 22 - *St. Louis*: Pacts/Pals Provider. Call 1-800-553-2712.
22 - *St. Louis*: Physiologic Stability and Physiologic State. Call Washington University 314-362-6891.

DECEMBER

6 thru 8 - *St. Louis*: Craniofacial Surgery. 24 credit hrs. Call Practical Anatomy Workshop 314-535-4000.
6 thru 8 - *Kansas City*: Oncology in Primary Care: Controversies in Cancer Detection and Management. Call CME office 573-882-0366.
7 - *St. Louis*: Nursing Home Administrators Conference. Call 1-800-553-2712.
7 - *St. Louis*: Bipolar Mood Disorder in Clinical Practice. 6.5 credit hrs. Call Washington University 314-362-6891.
7 - *St. Louis*: Contemporary Management of Congestive Heart Failure. 3.5 credit hrs. Call Washington University 314-362-6891.
9 - *St. Louis*: MRI of Muscle and Tendon Injuries. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
12 thru 14 - *Kansas City*: The Heart and Stroke in the 90's. 18 credit hrs. Call Kim McChesney 816-932-5140.
14 - *St. Louis*: Nursing Home Administrators Conference. Call 1-800-553-2712.
18 & 19 - *St. Louis*: Doppler Echocardiography. Call 1-800-553-2712.

JANUARY

8 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.
9 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.
13 - *St. Louis*: Applications of Breast Ultrasound. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
22 - *St. Louis*: The Ninth Annual Joseph E. Flynn Lecture Series. Call 314-569-6290.
27 thru 31 *St. Louis*: Medicolegal Death Investigators. Call 1-800-553-2712.

FEBRUARY

10 - *St. Louis*: New Insights into Costs and Motivations for Self Referral. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
15 - *St. Louis*: Diabetes Update. Call 1-800-553-2712.
21 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.
27 - *St. Louis*: OB/GYN CPT/ICD-9 Coding Workshop. Call 314-432-8712.

MARCH

8 - *St. Louis*: Hepatobiliary Disease. Call 1-800-553-2712.
10 - *St. Louis*: The Role of Nuclear Medicine in Assessment of Infections. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
12 thru 14 - *St. Louis*: The Tenth National Symposium Noninvasive Diagnosis of Vascular Disease. Call 314-569-6290.
14 - *St. Louis*: Bleeding Disorders. Call 1-800-553-2712.
21 & 22 - *St. Louis*: Integrated Care of the Thoracic Surgery Patient. A Seminar for Allied Health Professionals. Call Washington University 314-362-6891.

APRIL

11 - *St. Louis*: Allergy for the Clinician. Call 1-800-553-2712.
14 - *St. Louis*: Leroy Sante Lecture. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
18 - *Lake Ozark*: Mental Health and Aging. Call 1-800-553-2712.
21 thru 25 - *St. Louis*: Medicolegal Death Investigators.1-800-553-2712.
25 - *Branson*: Update: Primary Care. Call 1-800-553-2712.

MAY

12 - *St. Louis*: Radiologic/Pathologic Correlates in Bronchogenic Carcinoma. Call R. Gilbert Jost, MD, Malinckrodt Institute of Radiology at 314-362-7130.

JUNE

9 thru 11 - *St. Louis*: Strengthening Instructional Skills. Call 1-800-553-2712.
21 - *St. Louis*: Summer Geriatrics Inst. Call 1-800-553-2712.

Become a Key Contact

The 1997 Missouri General Assembly convenes on January 8. Before it adjourns in May, the legislature will consider some 300 bills that would impact your practice. It is vitally important that medicine's voice be heard. That is why we have developed the MSMA Key Contact Program.

The Key Contact Program is medicine's political strike force. It matches lawmakers with physicians from their district who will keep in touch on legislative issues. As a Key Contact, you will called upon to deliver medicine's message whenever important issues reach a critical point.

This direct approach has been very successful, and our Key Contacts enjoy it immensely! We want you to give it a try. It takes no special training - we'll guide you along the way. Just copy and fill out the form below and return it to MSMA, P.O. Box 1028, Jefferson City, MO 65102; or FAX: 573-636-8552.

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MMPAC Missouri Medical Political Action Committee (MMPAC) is the Missouri State Medical Association's bipartisan political action committee. The committee works with state elected officials to make sure they understand every aspect of health care legislation.

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Legislation & MSMA Policies Start with You

The process of creating legislation or policy supported by the Missouri State Medical Association begins with the ideas and needs of our members.

The first step is stating those needs in the form of a resolution. Resolutions may be submitted by individuals, component medical societies, or groups of MSMA members.

To have a resolution be included in the delegates' handbooks for the MSMA Annual Meeting to be held April 10-13, 1997, at Westin Crown Center, Kansas City. Resolutions must be submitted by **February 24, 1997**.

Submit resolutions to: **MSMA**
113 Madison, P.O. Box 1028
Jefferson City, MO 65102
or fax to 573-636-8552

Legislative Affairs Committee

David O. Barbe, MD, ***Mountain Grove***
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Frederick W. Hahn, MD, ***Independence***
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Charles Porter, MD, ***Kansas City***
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William Dorzab, MD, ***Kansas City***
**chair*

De Novo - A Program for Spouses and Families of Missouri Physicians

The Missouri Physician's Health Program (MPHP), under the auspices of the Missouri State Medical Association is available to help Missouri physicians suffering from alcoholism, chemical dependency and psychiatric illness. The aim of the program is to facilitate the physicians' return to healthy personal and professional functioning through early identification, intervention and treatment.

De Novo means "fresh start" and signifies hope and confidence in the future. In this program, the MPHP recognized that family members must also go through a process of recovery for the family to become viable and for the impaired individual to remain clean, sober and emotionally stable.

This philosophy of De Novo is implemented through a monthly support group for all spouses. This meeting provides an opportunity to share problems of recovery as experienced by the family. It also provides information and concepts which assist family members in understanding themselves and the role they play in enabling addiction or impairment.

Mental health counselors have come to understand that when a professional becomes impaired:

(1) It required the enabling support of the family to remain trapped in the impairment.
(2) It requires the healthy support of the family to enter a recovery program.
(3) It requires the healthy support of the family to maintain recovery.

As the impairment progresses, spouses often allow the victim of impairment to lie to them, to make promises which are not kept, and to set up an unreal world around the family which holds out the promise that everything will be all right if they continue to deny the problem.

As the family falls deeper into denial, rules become established to protect the denial:

Rule (1) "Don't talk." Keep what is going on in the family a secret. Don't answer your children's or family's questions. Don't discuss scenes which they see. As a result, the family becomes organized around a "big lie." The lie is, "everything around here is fine."
Rule (2) "Don't think." Don't seek information, consult professionals or attempt to identify the problem. This might endanger the breadwinner's career.
Rule (3) "Don't feel." Deny your feelings of anger, sham, guilt and resentment.

Once these rules are silently accepted by the family, the scene is set for a long period of emotional pain and turmoil.

During this time, the spouse is pulled back and forth by guilt, shame, resentment, insecurity and problems with children and finances. The longer this goes on, the more it changes the personality of the person dealing with the addict. The spouse experiences a major conflict between the desire to keep the family safe and the desire to get help.

In time, spouses alter the way in which they cope with the family's dysfunctional system. For example, it is not uncommon for financial responsibilities to become a major source of conflict and tension. As the spouse feels more insecure, financial decisions become a tug of war. Spouses become desperate to hold on to what they have. It is not uncommon for the impaired physician to be unable to make clear and healthy decisions concerning the family finances. As a result, in the physician is found to be overspending. This places tremendous stress upon the structure of relationships within the family unit. The children receive mixed signals about finances and many other areas of family life. Discipline may fall apart or become overly rigid.

Alcoholism is a family disease because the effect it has on spousal relationships as well as upon the relationships with the children.

Alcoholism is only one example of the types of impairment for which the De Novo Program is able to provide assistance. While it only one type of impairment, it does offer a useful model for viewing many other areas of impairment.

The De Novo Program offers the following as a means of promoting full family recovery:

(1) A treatment plan for family members as needed.
(2) Support group for spouses led by a therapist.
(3) Referrals to individual counselors.
(4) Family therapy referrals where indicated.
(5) Linkage to needed service in the community.

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Missouri Medicine

ournal of the Missouri State Medical Association December 1996

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In This Issue...

- ☐ MSMA-Your Representative Voice
- ☐ Computers in the Medical Practice
- ☐ Missouri Commercial Premiums Comparison
- ☐ Annual Convention Guest Speakers
- ☐ Radiology Quiz #10

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Missouri State Medical Association

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On the Cover:
"Poinsettia" is an acrylic painting on canvas by Carla Malone-Steck. Ms. Steck is a professional fine artisit and graphic designer in Jefferson City, Mo.

Editor's Desk

"Danger on the Information Superhighway"

J. Regan Thomas, MD, Editor

The Internet seems to be everywhere and its presence grows more every day. Importantly, its influence grows more and more each day - an interesting phenomena in a society that reports less and less trust in traditional institutions. The Internet has become a giant party line where rumors can pass from one person to millions with the click of the mouse.

Of concern to physicians should be the realization of the increase in medical information on the Internet.

Recently the Internet gossip factory tempted a veteran newsman who should have been more cautious and certainly should have been less naive. Pierre Salinger, a former presidential press agent, a news reporter, and television correspondent released a news story that suggested TWA Flight 800 had been shot down by a U.S. military missile. The story suggested a government or military cover-up and conspiracy to hide the truth about the alleged friendly fire incident. The only problem was that the story was not news. It had already been circulated and thoroughly investigated and debunked. And where did this veteran reporter get the information? Who was his source? It was the Internet World Wide Web. Apparently Salinger was not aware the story had been cruising the Internet for weeks. Unfortunately, this new medium was given credibility which it did not deserve and was trusted without the scrutiny that other sources of information would likely have been subjected.

The Internet World Wide Web is a tremendously popular component in today's electronic superhighway. There are few if any regulations as to who can use it or what can be placed on it. There is a tendency for the public to believe information on the Internet that they may question from other sources. That acceptance is problematic when at the same time there is reportedly an ever growing increase in false or unsubstantiated information, rumors or just plan gossip on the net.

Of concern to physicians should be the realization of the increase in medical information on the Internet. The medical information is not just comments by ordinary net users. Web pages are being established by very sophisticated groups but without the regulation that might be required elsewhere. Corporate groups and medical companies are aware of the access and impact.

This brings a new responsibility to physicians on behalf of their patients. We should be aware of the need to be the source of reliable, accurate information for our patients. We should understand that our patients will be using this technology more frequently and we should be ready to respond. We should urge our professional organizations and societies to use this opportunity to educate the public as well as to counteract the misinformation the other sources may have produced.

The world is changing faster than ever. The Internet is part of that change and medicine must make it part of its world too. Bogus information will always be part of the Internet. Physicians must always be available, including on the Internet, to set the record straight. MoMed

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"Physicians in Politics"

Daniel O'Sullivan, MD, MSMA President

The word from the wise is that physicians as a group will not step forward and take a position on controversial issues. The second word of wisdom is that physicians will never dig into their pockets and provide financial support for issues which would potentially pose a significant challenge to their profession. Allow me to announce with pride and pleasure that both of these premises are false!

In the Spring of 1996 my oldest son, Dan, Jr., announced that he would seek the candidacy for the office of Representative - United States Congress from the 1st District of Missouri. This is a seat which has been occupied by Democrat William Clay for twenty-eight years. Mr. Clay is a former leader of the Black Coalition in Congress and a formidable force in politics.

My family and I have lived in the 1st District of Missouri for forty years excluding two years when I was in the military service. I have felt a personal lack of representation of my ideas and principles for this entire period and welcomed the enthusiasm and innocent optimism of a new face in politics.

At first blush it would appear that the challenge was insurmountable. We are reminded, however, that Thomas Foley was defeated while sitting as Speaker of the House of Representatives. Many other powerful forces have been unseated in the face of scandal and voter dissatisfaction. This ambitious project generated a twinkle of hope and quickly engendered the support of my rather large family. Begging for money has never been a chore which I anticipated with delight, however, I have known the generosity of individuals in charity drives and felt we might be able to build a nest egg.

Where should we turn except to physicians. My son is not a doctor but is the son of one and grandson of two physicians, all graduates of St. Louis University School of Medicine. He understands and supports all the needs of health care and in his own mind has come to appreciate and support what we all feel is a fine medical system.

To get to the point, physicians responded with incredible generosity and from the physician community we were able to raise nearly $50,000. This included generous support from American Medical Association Political Action Committee and Missouri Medical Political Action Committee and the American Association of Physicians and Surgeons and other groups. Most of the money, however, came from practicing physicians who dug into their pocket and wrote checks of support for a political campaign which had a better chance of failing than succeeding. Physicians, many foreign medical graduates, who had heard his views opened their homes to Dan for fund-raisers and provided surprisingly generous support for the campaign. Obviously, these individuals felt strongly about their citizenship and the opportunity for us all to express our views.

My son worked hard, made countless personal appearances, and represented himself well. He and his wife, Susie, made their home headquarters, they spent the funds which were raised discreetly, and won the primary over five opponents with a plurality of 47 per cent. On Nov. 5, Mr. Clay was reelected to the Congress and a young man with political ambitions suffered his first defeat. He received tremendous support in the North County, in Clayton, in Richmond Heights and the other fringe areas of the county, and actually won the vote in several of these townships. The count in the City of St. Louis, of course, was devastating.

The lessons we learned, however, have nothing to do with numbers. They have to do with people. A family worked hard together and developed an even tighter bond in this sincere effort. The thing that impressed me again was the unexpected and incredible generosity of the physicians of this community who more than rose to the occasion of support and proved that we as citizens are willing to stand up and be heard. This provides great encouragement to those of us who have dedicated our time to organized medicine knowing that the individuals we represent feel as strongly about important issues as the rest of us.

The O'Sullivan family says "Thank You" to the medical community for your help and support and God Bless America. MoMed

Radiology Quiz #10

by Roger A. Francis, MD

Radiology Department, Lake of the Ozarks General Hospital

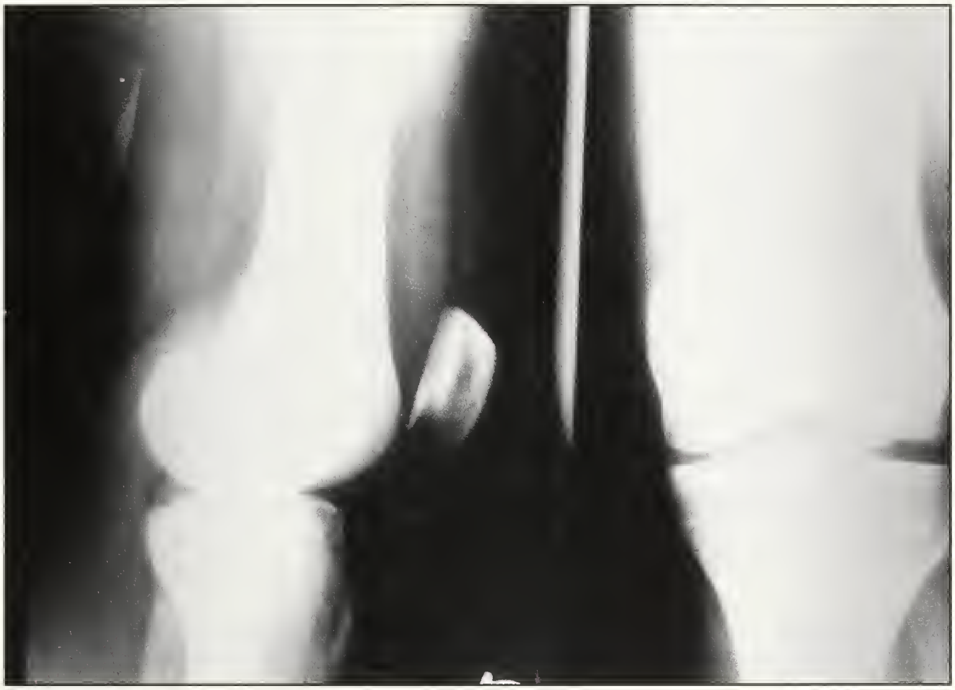


Figure 1

A 17-year-old man presented to the emergency room after a fall with severe left knee pain. Anteroposterior and horizontal beam lateral views of the knee were performed (Fig. 1).

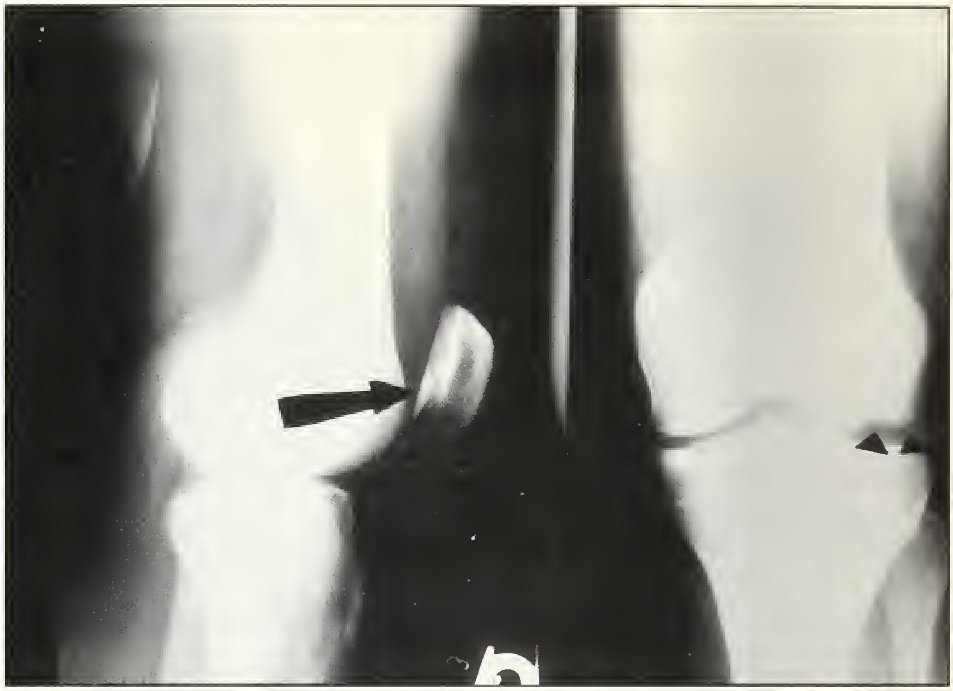
What is the diagnosis?

a. Tibial plateau fracture
b. Hemarthrosis secondary to ligament injury
c. Osteochondral fracture of femur
d. Patellar fracture

(See answer on next page.)

Radiology Quiz Answer

The Radiology Quiz question is located on the previous page.



Repeat Figure 1

ANSWER:
c. Osteochondral fracture of femur

The cross-table lateral view of the knee (repeat Fig. 1) shows moderate joint effusion with a fat-fluid interface in the suprapatellar bursa, indicating a lipohemarthrosis. This finding is strongly suggestive of a fracture about the knee, resulting in extrusion of marrow fat into the joint. The lateral view also shows a small fracture fragment (arrow) overlying the inferior patella, although the patella itself appears intact. The anteroposterior view shows a zone of cortical discontinuity at the articular surface of the lateral femoral condyle (arrowheads), indicating an osteochondral fracture (Option C is the correct response). This diagnosis was confirmed surgically.

The tibial plateau and patella appear intact, making Option A and D incorrect. A ligament or cartilage injury alone would not usually cause a lipohemarthrosis; therefore Option B is incorrect.

Osteochondral fractures are relatively common injuries which are frequently missed radiographically. This is because there is usually only a small cortical bony fragment with the articular cartilage fragment, and the small fragment may be overlooked on plain radiographs. Small bony fragments within the joint may project into the suprapatellar bursa, behind the patella (as in this case) or elsewhere in the joint space.

Although osteochondral fractures are often diagnosed arthroscopically, magnetic resonance imaging is an excellent, non-invasive modality for diagnosing these injuries. Superb contrast resolution of cartilage and bone allows detection of even subtle osteochondral injuries as well as bone bruises.

Osteochondral fractures occur most commonly in adolescents and young adults, and are commonly associated with dislocations of the patella. The most common site of injury is the lateral femoral condyle.

References

1. Rogers, LF. *Radiology of Skeletal Trauma*, 2nd Edition 1992, Churchill-Livingstone, pp 1272-81.
2. Vellet, AD et al. Occult posttraumatic osteochondral lesions of the knee: prevalence, classification and short term sequellae evaluated with magnetic resonance imaging *Radiology* 1991;178:271-276.

Maximize Your Dues Dollars

Beverly Murrell, MSMA Alliance MMPAC Chair

Now is the perfect time to jump ahead into the MMPAC-AMPAC 1997 fiscal year (January 1 - December 31) and to maximize your membership dollars!

As you know, the Missouri Medical Political Action Committee - this arm of the medical profession - is a voluntary, non-profit, unincorporated group of physicians, spouses and medical society staff who band together around common interests in support of candidates who share their views.

Political education activities in 1997 include a five-day AMPAC Campaign School in February, the biennial AMA Political Grassroots Conference in the Capitol with the nation's leaders in September, and "Medicine's Candidate: A Prescription for Political Success" designed for any AMA member physician or physician spouse considering a bid for elective office.

MMPAC also contributes directly and in kind to senators and representatives (and candidates) deemed "friendly" to Medicine.

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Each member will receive a membership card and pin, as well as issues of The Sustainer and Political Stethoscope.

For information on Grassroots in a High Tech Era, contact the Division of Political Education at (202) 789-7464. Also, there is a GRASSROOTS HOTLINE for most current information: 1-800-833-6354.

Please contact me for further information or envelopes. If you are a county MMPAC chairman appointee, please let me know. Contact Beverly Murrell, MSMAA MMPAC Chair, at 573-445-4822. MoMed

Season's Greetings!

The following members of the MSMAA Board and the MSMA Council have contributed to the American Medical Association Education and Research Foundation in lieu of the Holiday Greetings.

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MSMA - Your Representative Voice

Jeff Howell, MSMA Director of Field Services

"What can the MSMA do for me?" That was the question most commonly asked of me at the recent Missouri Society of Internal Medicine - American College of Physicians meeting at the Lake of the Ozarks. The actions of the MSMA speak for themselves. A quick scan of the 1996 Legislative Report usually answers the question. Similarly, so does the membership brochure, which outlines MSMA benefits.

However, when MSMA members ask their fellow physicians to join, the question "Why?" is always asked. How do *you* answer this question?

The answer is quite simple really. Chapter I, Section 2 of the MSMA Bylaws describe the six classifications of membership. Active membership encompasses the majority of our members and represents those who are the most involved in the Association. Remember, the MSMA is a representative organization which serves individual members through the resolution process, the House of Delegates and Council. A physician who is not active in the Association is at a great disadvantage compared to a member who participates in MSMA activities such as serving as a delegate or becoming a Key Contact. Sometimes physicians who have become disenchanted with organized medicine quit. The proper course of action is to get active and change what you think may be wrong by submitting a resolution. Don't quit. The MSMA's collective voice throughout the state is our top benefit and makes the MSMA your greatest ally.

"What can the MSMA do for me?"

The MSMA provides a democratic forum where you, along with your colleagues from across the state, can raise and debate issues, reach a consensus and formulate policy. MSMA policy is then translated into practical actions on issues that affect you and your practice.

In 1996 alone, the MSMA monitored over 1,300 legislative bills for their impact on physicians' practices and patients' health. The MSMA sponsored the Patient Fairness Act which would restore and preserve clinical autonomy by requiring due process and other important legal rights for physicians in managed care organizations. Furthermore, the MSMA continues to play a major role in the creation of 1997 health care legislation presently being formulated by a interim legislative committee.

The MSMA and your local medical society provide powerful advocacy for physicians and patients alike. While the MSMA represents you and your patients in Jefferson City, your local society works hard on your behalf with the local media and other entities.

The MSMA offers quality publications and services, such as MoMed Net, Tax Resource, insurance programs, CME offerings, and others.

All this for only $300; the lowest dues of any state in the nation.

For your information, the MSMA recently solicited about 4,500 Missouri physicians in our annual statewide non-member mailing. The mailing included a letter from Dr. O'Sullivan, an informative brochure and the final 1996 Legislative Report. We have received 43 responses and I believe that this mailing can be considered successful. Although not a great percentage of the whole, it is still 43 members to add to the physicians' voice in Missouri. As responses continue to arrive at the MSMA office, your staff has been continuously sending applications and brochures to prospective members. You can see a list of new MSMA members in this journal every month and we strongly urge you to give these physicians a personal welcome.

Please don't forget to ask a non-member to join. I hope you find asking physicians to join the MSMA and answering their questions more simple.

MoMed

Membership Notes

New Members

Boone

Brian S. Hecht, MD
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Columbia, MO 65212
University of Virginia: 1987

Cole

Jody A. Rodgers, MD
1620 Southridge Dr., Ste. B
Jefferson City, MO 65109
University School of Medicine
Philadelphia, PA: 1989

North Central

Warren I. Williams, MD
630 W. Third St.
Sullivan Co Mem Hosp
Milan, MO 63556
University of Colorado: 1962

South Central

Dennis Higginbotham, MD
805 Kentucky, Suite 3
West Plains, MO 65575
University of Kansas: 1991

St. Louis Metropolitan

John T. Porvaznik, MD
12647 Olive Blvd.
St. Louis, MO 63141
University of Harvard, 1958

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Dr. Ronald Evens, director of Mallinckrodt Institute of Radiology at Washington University, was installed as chairman of the Board of chancellors for the American College of Radiology.

In Memoriam

Robert L. Frazier, MD, 69, Sikeston, died October 30, 1996. He graduated from Central Methodist College in 1949. In 1953, he received a bachelor of science degree in medicine from the University of Missouri-Columbia. In 1955 he received an MD degree from the University of Cincinnati. He served in private practice from 1957-69 and from 1979-83 was director of medical services for the Sikeston Regional Center and medical director at the Sikeston Convalescent Center. He was a staff physician at the Sikeston Regional Center and Southeast Missouri Residential Services. He was a member of the Mississippi County Historical Society, Missouri Council of the Arts, American Cancer Society, American Medical Association, Missouri Association of Family Practice, American Association of Family Practice, and the Missouri State Medical Association.

Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category I programs.

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Computers in the Medical Practice

Glenn L. Gordon, MD, FACIP

This article is part of a series covering the ever-expanding role of computers in the medical office and practice by Glenn L. Gordon, MD, FACIP. Dr. Gordon is Director, Center for Digestive and Liver Diseases, Clinical Instructor of Medicine at St. Louis University School of Medicine, President of Audrain County Medical Society, Immediate Past President of American Cancer Society - Audrain Unit, and State Council MSIM/ASIM Delegate.

This is the first of a series of articles covering the expanding role of computers in our medical practice from office management programs to the Internet. This month's article covers the computerized medical record and what it can do for you.

Computerized Medical Records

Computerized medical records (CMR) are based upon the physicians' need for content, organization and retrievability of clinical information. A medical record should be a faithful record of the clinician's observations, what they have heard, seen, thought and have done. As such the record must be authentic, giving a faithful account of the clinician's understanding and be formulated in terms in which they found natural. An additional requirement of the medical record includes allowing descriptions to arbitrate levels of detail and allow statements to be expressed at the clinician's natural level of abstraction. Observations are made regarding what has been heard, seen and done, and "meta-statements" recording the decision making process, the clinical dialogue and data entry process. CMR allow not only clinical management to the patient, but it also allows a base for performing clinical research, basis of reimbursements and provides legal documentation. It allows increasing communication between providers, reminders and decision support.

Currently, for every five minutes with a patient, a physician spends four minutes charting. Thirty-eight percent of the physician's clinical time is spent in charting (Mamlin - 1973). Realizing that up to 70% of patient management questions remain unmet and management might change four times a day, there is an obvious need for CMR.

CMR provide reliability, availability, readability, expert system functions, reminders and cost of care. Its goal is patient-focused, multi-disciplinary and collaborative integration across various sites and is cumulative over time. Regarding a change in environment with managed care and capitation resulting in a differentiation in roles of primary care physicians (PCP) and specialists, there is a need for systems to track referrals and communicate between providers. In addition, there is a need for all providers to prove and document efficiency with increased blurring of the inpatient/outpatient lines and the increasing roles of physician extenders in increasing availability of computerized data.

New needs of providers that lend itself to CMR in capitalizing essential time, space and motility issues and give physicians the tools for practicing better medicine and surviving capitation. Outcome indicators can be provided for "evidence-based" medicine and computerized

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decision support in making outcome measurement events routine (cost/quality).

Computerized decision support provides effective information, display and exposes redundancies. It provides less expensive alternatives while emphasizing important problems, providing probabilities and making guidelines/algorithms accessible.

Time/Space Motility Issues

Many providers care for patients in time and space making coordination vital, i.e. communication. Providers are working in multiple sites. Patients are more mobile these days as more care is delivered at home or patients want more access to medical information. CMR allows for the growing need for access involving the "health care team." It includes the patient's involvement in his or her care/process and allocates resources assuring quality, evaluates reimbursement in billing issues, evaluates policies of public health and allows for clinical research. Investment in information technology is a matter of competitive necessity in the 90s and going into the next an millennium.

Robert E. Mittelstaedt, Jr. reporting in the *Group Practice Journal* gave the following:

"If you were to wake up tomorrow and find that your competitors have the ability to track services, quality, patient demographics, situation-driven recalls, direct electronic ties to the pharmacy and insurance company, on-line claim reconciliation and funds transfer, claim filing for patients, expert systems to predict patient conditions and recommend treatments, direct monitoring of patient symptoms from home or remote sites and the ability to instantly transfer a complete record anywhere in the world for a traveling patient, would you be worried?"

What is the ideal CMR? The ideal CMR needs to be user friendly in terms of software interfacing connected to a robust computerized database. It should have the ability to easily record, integrate, aggregate, organize and abstract data during the patient examination and treatment decision process. It should provide the foundation for storing data that later can be transformed into useful information to be used in broader population-based decision making. As medicine is an information-intensive field, when information is available at the time of the decision a better (higher quality) and a more efficient (faster) decision will result.

An increasing amount of physicians are already using computers in their practice. The current use of computerization in the medical office has historically been for administrative and billing systems of which there are approximately 1,500 to 3,000 different practice management systems in use. The exact number is difficult to verify due to many of these provided by small vendors and used by less than 50 practices at a time. When selecting a computer for a medical practice, it is important to select the system based on features and functions desired for your clinical environment, including billing, scheduling, ease of use, reminders and electronic data submission as computer platforms and software packages are constantly evolving. It is essential that this information become portable in the future to transfer to new systems at a reasonable charge once technology catches up. As managed care continues to grow, there is an increasing requirement for data analysis in both clinical and administrative areas. It will be imperative for the physician to evaluate various aspects of their practice, to assess capitation rates and to negotiate effectively with other health care entities, such as hospitals, preferred provider organizations, and third party payors. In addition, many managed care organizations (MCOs) are evaluating the quality of practice by chart audits and periodic screenings. Having a system that is capable of tracking and generating reminders as preventive services help the medical practice in a high rate of compliance with current recommended guidelines in proving thus, not only quality, but also leading to increased reimbursements.

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Holy Grail of Computerized Medical Records

1. Problem List
2. Measures of Health Status and Functional Status
3. Documented Clinical Reasoning and Rationales
4. Longitude and Records with Timely Linkages to Other Patient Records
5. Confidentiality, Privacy and Audit Trails
6. Continuous Access for Authorized Users
7. Supports Simultaneous Multiple Users
8. Supports Timely Access to Local and Remote Information Sources
9. Facilitates Clinical Problem Solving
10. Supports Direct Data Entry by Physicians and Other Health Care Workers
11. Supports Practitioners in Measuring and Managing Costs, Improving Quality
12. Systems have Flexibility to Support Existing or Evolving Needs of Each Specialty

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Holy Grail of CMR

The following twelve attributes described by medical informatic experts comprise the "Holy Grail" of computerized medical records. The implication is that while most medical records have some of these attributes, the perfect medical record system is yet to be created.

1. Problem List

The problem list, progress note and encounter form should be integrated. One of the most tedious chores in the medical office is the completion of various forms. Often the information that is needed is organized in different formats. A good medical record system should allow the user to enter the information only once and still be able to complete the multiple forms. For example, when entering the patient's diagnosis for the first time, the system should provide an appropriate list of terms for the problem list. It then automatically generates the appropriate billing and encounter forms regarding the use of ICD-9-CM codes for the diagnosis and CPT-4 codes for the billable procedure. The records should reflect a history of medical problems, how these problems have been addressed in the past and their current status and a treatment plan. An emergency room physician would treat a 25-year-old man with chest pain differently and more efficiently if he had access to a problem list that notes esophagitis versus a history of coronary artery disease as an active diagnosis.

2. Measures of Health Status and Functional Status

Surprisingly, little attention has been paid to these measures. Each physician traditionally has carried this information in his head. He was only aware of the health status of the patients when he saw them in his office setting. With the health and functional status of the rest of the general population unknown, little could be done to improve it. Now, as the attention focuses on maintaining the health of the population rather than treating an individual's episode of illness, managed care plans are interested in quantifying the health status of their members. The plan, thus, is to demonstrate improvement in total health in the population to satisfy members and to use as a marketing tool for

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employers and investors. Some CMR have added a verified health assessment tool, although they take time to answer, providing invaluable information for assessing patient populations.

3. Documented Clinical Reasoning and Rationales

As health care is delivered by more highly organized and efficient medical teams, the reasoning behind medical decisions must be documented so that other team members may understand the justification behind the plan initiated. A primary care physician (pcp) is more likely to carry out an unfamiliar cardiologist's treatment recommendation if he sees the documented clinical reasoning and not merely a set of orders without a diagnostic context. If the PCP does not understand the specialist's reasoning process, he may second-guess or ignore treatment recommendations. Documenting clinical reasoning becomes increasingly important as managed care plans restrict referrals, sever well-established relationships between patient and physicians and ask them to work within new and unfamiliar networks.

4. Longitude and Records with Timely Linkages to Other Patient Records

A health care provider must be able to see not only timely data but also information gathered on his patient across all episodes of care over the patient's lifetime. This information should include activities at other sites, such as other practitioners' offices, specialists' clinics, laboratories, radiology, imaging facilities and hospitals. Assessing patient's risk factors for disease in his or her social, economic, cultural and psychological background and current characteristics are beneficial. At the population level, clinicians need information about patterns of mortality and morbidity as well as about the environmental, political, economic, cultural and demographic influences on overall health and illness. This information could be gathered in seconds in collecting radiological, pathological and hematological data and arranging them statistically or graphically allowing for rapid interpretation by treating physicians.

5. Confidentiality, Privacy and Audit Trails

Many current systems contain audit trails, only a few even have a modest security system. With on-line access capabilities, privacy concerns increase.
A well established protocol and "firewalling" measures are being implemented providing increasing security for operating systems and database security and the need to be maintained in the future.

6. Continuous Access for Authorized Users

Unlike paper or hard copy storage techniques, electronic data storage systems mandate a "fault-tolerant system." A physician cannot be unable to give critical information at hand because his computer "crashed" or his hard disk failed and all the data perished. Thus, the ideal CMR is configured in a client-server architecture with sufficient redundancy to insure the integrity of the data with frequent backups and storage on and off site. With the access to a recent data backup in a redundant system, a physician would have the capability of immediately accessing the same information.

7. Supports Simultaneous Multiple Users

The CMR will allow electronic access to the complete patient record for all providers facilitating communication among its various health team members. The organizational silos that operate inpatient and outpatient medical and surgical, Medicare and Medicaid, etc. are utilized increasingly in delivering health care. The inability to integrate information across systems, network and multiple sites can result in organizational, clinical and financial chaos. Standards need to be established and agreed upon in which to effectively communicate among the physicians and allied health care providers. Networking is the term utilized to help share multiple streams of data into a single database which would then have demonstrated improvement providing health care. The "common domain information" model for the client database has

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expanded use based in Europe but remains rare in the United States except for those in rural communities. In these rural communities the "Community Health Information Network" (CHIN) is being increasingly utilized, storing information about members of rural communities on to a mainframe computer database. All patient providers can access this information through the so called CHIN through their PC's using a client-server architecture. A functional example would be a small community where local physicians can share the same patient database with two clinics, a 50-bed hospital, a nursing home, etc.

The biggest challenge that still remains in CMR is the ability to integrate into one database all the information stored from different departments. Having information to allocate scarce medical resources appropriately will result in an overall increase in health of the population at risk. For example, if physicians know that the immunization rate for children less than 12 years old in the community is 98% but the immunization rate for pneumococcal vaccine in the elderly is less than 50%, they would be better off spending time and resources with those elderly patients rather than embarking on a school-based immunization program. Information such as this allows more adequate allocation of local medical resources in various communities.

8. Supports Timely Access to Local and Remote Information Sources

Researchers at the University of Southern California School of Medicine reported only 30% of the physician's information needs are actually met during the patient encounter. This information is usually provided by another physician or health care professional. Physicians report lack of time and access to printed material, lack of time to seek information, lack of organization of articles they have saved, and lack of knowledge of an appropriate source of information. Providers need a rapid access to information resources such as MEDLINE, Index Medicus, MeSH and MEDLARS. Such services provide recent citations about a diagnosis, treatment or symptom. On-line literature searching has demonstrated statistically significant decreases in medical costs, charges and lengths of stay in patients whom MEDLINE searches were conducted in the first half of the hospitalization. The use of on-line accessing or CD-ROM systems allow individual health care professionals and students to search MEDLINE and other databases and allow users to obtain new information sources and exchange full text documents. These then can be linked up into individual medical records as a resource for the physician to access in subsequent patient encounters.

9. Facilitates Clinical Problem Solving

Clinical decision-support software is widely available encompassing simple standard preventative care and disease-specific reminders or as complex as computer-assisted diagnosis and treatment regimens. Preventive care measures encompass routine inoculations, pap smears, mammography and flexible sigmoidoscopies. Disease-specific reminders concentrate on secondary prevention techniques. For example, in a diabetic patient, the following tests might be suggested at the time of the clinical visit: blood glucose, hemoglobin A1C, yearly eye exams, etc. It has been shown that computer reminders increase appropriate physician responses to abnormal exams, lab findings and x-ray results, resulting in a significant reduction of inpatient costs and lengths of stay by having access to information for cost comparisons of antibiotics, warnings, recorded allergies, drug interactions and suggestions for appropriate intervals of subsequent testing. Thus, computer-generated clinical reminders act as a prospective quality assurance program, reducing clinical errors based on protocol-based computer models and help to improve favorable outcomes.

A medical decision-support system or computer program is designed to help health care professionals make clinical decisions. Some prototypes

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include the QMR, a program developed at the University of Pittsburgh as a decision-support software tool. Given patient demographics, complaints and physical findings, the program uses algorithms to develop a list of potential diagnoses in descending or ascending order and gives suggestions for further testing to support that diagnosis. Other programs such as Iliad and DXPlain provide clinical guidelines that suggest management options once a diagnosis is reached. These can help standardize practice patterns and eliminate variability among health care professionals, providing a framework from which to work with. These programs lack the ability to abstract data already entered into the electronic CMR. With standardization of vocabulary and recognizing only specific words and phrases limits its effectiveness. For example, hematemesis after forceful vomiting may have a different etiology than a presentation of hematemesis with a first episode of vomiting. Programs such as these do not make this distinction. Clearly these are educational tools and enhancements are needed to provide more accurate information to allow ongoing decisions in the medical practice environment.

10. Supports Direct Data Entry by Physicians and Other Health Care Workers

Many methods exist for entering data, varying from the keyboard to the mouse to a pen tablet and voice recognition software, all of which are now available on different systems. Whichever technique is used, it must enable the providers to develop timely, legible notes, with the time required for entering into the system being a limiting factor in active clinical practice. If it takes the physician longer to enter a note in the computer than it does to handwrite it, the physician will often not use the system. The use of templating and macros designed by specialists and PCP's that are problem driven help overcome some of these initial time constraints.

11. Supports Practitioners in Measuring and Managing Costs and in Improving Quality

The ability to profile practitioners by test, drug, procedure or therapy patterns are becoming increasingly mandatory as physician groups begin to assume risk. The profiling of providers is the fist step toward managing utilization and quality. As medical management in a group or network becomes more mature, "data mining" occurs. Choosing the least expensive of two comparable therapies could result in significant cost savings in a provider network. Data mining is a new term in health care informatics, which is defined as "extracting unknown information from existing data often with the help of an artificial intelligence program, using statistical and visualization techniques to discover and present knowledge in a form that people easily can comprehend."

For example, through data mining one call tell not only how many endoscopies are done in the inpatient setting, but also can determine how many could have been done in an outpatient setting at a much lower cost and which gastroenterologists were doing which procedures. In addition, what is spent on antibiotics, which ones account for the greatest expense, which ones are most appropriate for the diagnosis and which physicians ordered them could be assessed through data aggregation with the CMR and data mining. In addition, retrospective quality assurance reviews, once very time consuming, could be performed within minutes and analyzed leading to sometimes unexpected deficiencies. In addition, retrospective analysis of clinical data could determine the future needs of a population at risk providing measures for prospective assessments in the medical delivery system. This modeling would identify the optimal configuration of providers, ancillary services and facilities to serve the population at risk. For example, a population of 10,000 college students would require a considerably different and probably a smaller medical delivery system rather than a population of 10,000 Medicare recipients. This analysis and modeling of community needs will be essential for delivering more effective health care.

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12. Systems have Flexibility to Support Existing or Evolving Needs of Each Specialty

As physicians' work increasingly in multispecialty groups, the single CMR must be flexible enough to accommodate the peculiar needs of all specialties within a certain group. This includes, among others, unique vocabulary, procedures and therapies.

Population-Based Medicine

Population-based medicine looks at the treatment of large groups rather than individuals. Treatment plans are derived from the review of epidemiologic, statistical and cost-effectiveness data. I am not sure this data can be recorded and retrieved through the CMR. Its orientation is towards improving the health of the group rather than crisis-managing disease, and therefore places a greater emphasis on disease screening and primary or secondary preventive care. The CMR allows the physician to provide data from the perspective of a population, not just an individual. Population trends can be analyzed regarding symptoms, complaints, diseases, surgeries, infections, radiological testing, length of stay and drug utilization Identifying and measuring trends provides an opportunity to affect not only the quality of care but also clinical and final outcomes. By analysis of the patient encounter data, a physician can evaluate the appropriateness of treatment with the help of decision-support tools and the over- or under-utilization of diagnostic tests or specialists through comparative patterns established by national or local benchmarks available on-line.

The Future of CMR

A truly integrated CMR is not an inexpensive proposition and millions and billions of dollars will be spent in the next years, developing the "ultimate system." No system yet is capable of integrating and utilizing all available data streams, mainly due to technological and syntactical differences in data storage and transmission. Standards need to be developed for medical data, codification, transmission and integration and establish a common base vocabulary for every term used in the practice. Nearly every term used in the practice of medicine has a unique meaning in the context, be that of an individual practitioner, hospital or clinic. Although this task appears daunting, standardization of data is occurring and will result in the ability for the CMR to easily integrate the various data streams in the future.

Summary

It is clear that a successful medical practice needs a competent, caring physician as well as office personnel that understands how to manage that office. Thus, the CMR provides a source of information and tools for managing that information. It allows the physician to develop the seemingly paradoxical skills of decreasing the cost of care in populations while increasing the efficiency and quality of care delivered. This becomes increasingly necessary as medical practices are demanding more of paper-delivered systems leading to inconsistencies between paper clinical records, computerized financial records, etc. The comprehensive, integrated electronic and computer information system will become a necessity for medical practices in the future. Patients are prepared to accept clinician use of computers and providers will continue to use these systems in increasing numbers if they are designed to meet their needs, save time and increase potential earnings.

CMR in your practice requires standardization of terminology, the ability to integrate with local systems, the ability to combine data, capture other needs of your practice and allow multiple formats to be supported into a standardized nomenclature as adopted. As physicians struggle to allocate resources and control costs successfully, the need for population-based data is imperative on a local, regional and national level. CMR provide tools for aggregating this data for deriving new information from so-called data mining by retrospectively evaluating patient populations providing means to prospective implementation making this faster and more accurate information-based decisions as well as performing

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prospective quality assurance in retrospect of utilization review and physician profiling. These are the tools that will carry us into the next millennium in providing an integrated delivery of quality health care to our patients. MoMed

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MSMA General Session Speakers

Mr. Steve Wetzell
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MSMA General Session

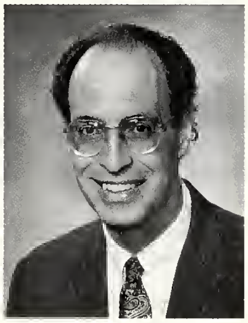
April 11, 9:00-10:30 a.m.

Mr. Steve Wetzell is the executive director of the Buyers Health Care Action Group (BHCAG), a coalition of 24 Twin City-based employers providing health care for 400,000 employees, retirees, and dependents throughout Minnesota, western Wisconsin and eastern North and South Dakota.

MSMA General Session

April 11, 2:30-4:00 p.m.

Mr. Edward Hirshfeld is Vice President and Associate General Counsel for Health Law of the American Medical Association (AMA). He directs the Health Law Division of the AMA, which is responsible for medico-legal policy initiatives and for counseling the Association about health law issues. The Health Law Division is responsible for coordinating the AMA's initiatives in the managed care area.



Edward Hirshfeld, JD
Chicago, IL

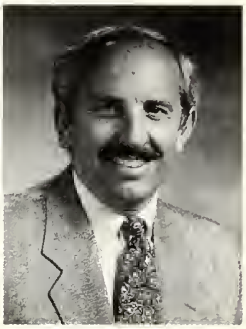
Mr. Robert F. Leibenluft is Assistant Director for Health Care of the Federal Trade Commission's Bureau of Competition. Mr. Leibenluft writes and lectures extensively on health law topics. His articles on health care have appeared in The New England Journal of Medicine, Vanderbilt Law Review, The American Journal of Psychiatry, Business and Health, Pharmaceutical Executive, Medical Devise & Diagnostic Industry, The BBI Newsletter, and other books and journals.

Robert F. Leibenluft
Washington, D.C.

Organized Medical Staff Section General Session

April 12, 10:00 a.m. - 12:00 noon

Joseph Green, PhD, has served as Director of Continuing Medical Education and Vice President of Medical Education for Sharp HealthCare, an integrated health care system in San Diego, Ca., since 1989. He is also president of Professional Resource Network, Inc., a consulting firm which has provided assistance to several national specialty societies, medical schools, voluntary associations, and hospitals.



Joseph Green, PhD
San Diego, CA

Robert Pyatt, MD, is serving as the acting Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians. He has been serving for the past four years as an ACCME national surveyor. Dr. Pyatt has been selected to serve on the Board of Examiners with the 1996 Malcolm Baldridge National Quality Award; only a few physicians in the United States are selected for this honor, and he is the first member of the CME community who has achieved this status.

Robert Pyatt, Jr., MD
Chambersburg, PA

MSMA Annual Convention

April 10-13, 1997

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Hotel reservations must be made prior to March 1, 1997. *Contact the MSMA for more information.*

1997 Convention Deadlines...

Citizenship and Community Service Awards
Nominations should be submitted in writing to the MSMA office or through a local component medical society. **January 22, 1997.**

Resolutions for Delegate's Handbook:
Resolutions may be submitted by individuals, component medical societies or groups of physicians. **February 24, 1997.**

Members for the House of Delegates:
Component Societies should be preparing to send Delegates to the House. Each society will be notified as to the number of delegates they can send.

Information...

If you have information to include in the
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MSMA Preregistration

The 1997 Annual Convention offers a large variety of educational activities. To assist you in attending these programs, we ask that you complete and return this convenient preregistration form.

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HMO Per Member, Per Month Competition Hits Missouri

Patrick J. Mills, CPA, MBA, MSMA Director of Health Care Finance

The Missouri Department of Insurance recently released its 1995 HMO Report. One specific table in this publication, Commercial HMO Premiums, indicates premiums overall were moving down in 1995. See next page for table.

What follows is an analysis prepared by MSMA, not the Department of Insurance, highlighting the peculiar nature of the HMO industry. In other words, it is difficult for any statements to be equally applicable to all HMOs.

Per Member/Per Month Commentary

The Per Member/Per Month (PMPM) declines were led by two HMOs with double digit decreases - BlueChoice (Blue Cross Blue Shield of Missouri) and Group Health Plan also of St. Louis. Most of the PMPM decreases were on the part of HMOs reporting a net income for 1994.

Of the nine HMOs reporting increased PMPM premiums, most (five) had $10 million or less in premium revenue. Exceptions to this were Principal Health Care of St. Louis which had a 6.8% increase with over $50 million in premium revenue and Blue-Care which had an increase of more than 10% with over $20 million in premium revenue. Two very large HMOs, GenCare and Humana each increased their PMPM by less than one-half percent.

Interestingly, of the five lowest PMPM premiums, three are very small in terms of revenues - Mercy, Citizens, and Community - and the other two are part of the United HealthCare giant - GenCare and PHP. One perspective is that HMOs "buy" the business early and the purchaser is forever paying for the first year's low price. Another is that larger HMOs are becoming more efficient and are in a better position to pass on savings resulting from administrative efficiencies or are in a better position to compete based on price. Again, generalizations are not universially applicable.

MoMed

For a copy of the
"Missouri HMO Report 1995,"
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	Commercial Premiums						
	Per Member Per Month		Change	Net Income	Commercial Premiums		Change
	12/31/95	12/31/94		12/31/94	12/31/95	12/31/94	
BMA Selectcare, Inc.	$116.19	$100.91	15.1%	$231,143	$4,446,159	$8,507,786	-47.7%
*CIGNA HealthCare of Kansas/Missouri, Inc.	149.40	101.56	47.1%	(4,653,980)	5,862,120	6,119,588	-4.2%
*CIGNA HealthCare of St. Louis, Inc.	132.81	136.18	-2.5%	---	8,064,040	9,083,850	-11.2%
Citizens Advantage	95.63	86.43	10.6%	(456,936)	2,109,563	1,104,749	91.0%
Community Health Plan	107.59	----	----	---	2,853,285	----	----
Exclusive Healthcare, Inc.	114.34	120.58	-5.2%	(4,804,248)	4,755,192	5,142,646	-7.5%
*GenCare Health Systems, Inc.^	109.58	109.30	0.3%	22,350,318	236,078,250	221,193,136	6.7%
Good Health HMO, Inc., d/b/a Blue-Care, Inc.	134.48	122.18	10.1%	4,315,792	22,854,227	21,877,390	4.5%
Group Health Plan, Inc.^	118.52	134.98	-12.2%	426,177	125,575,308	121,641,588	3.2%
HealthLink HMO, Inc.	111.97	115.42	-3.0%	(684,119)	10,130,695	4,169,520	143.0%
HealthNet, Inc.	129.33	123.34	4.9%	(2,101,896)	10,276,189	6,022,427	70.6%
*HMO Missouri, Inc., d/b/a BlueChoice^	115.46	133.43	-13.5%	8,542,394	92,597,089	90,082,900	2.8%
Humana Health Plan, Inc.	114.75	114.30	0.4%	21,483,444	35,239,194	5,561,712	533.6%
Humana Kansas City, Inc.	125.34	135.43	-7.5%	3,151,347	90,004,761	86,116,648	4.5%
Kaiser Foundation Health Plan of Kansas City, Inc.	126.77	130.86	-3.1%	863,446	67,983,131	67,695,655	0.4%
Medical Center Health Plan, dba Partners HMO	114.45	121.55	-5.8%	1,447,863	64,128,108	60,093,925	6.7%
Mercy Health Plans of Missouri, Inc.	94.55	----	----	---	1,071,513	----	----
MetraHealth Care Plan of Kansas City, Inc.	124.30	122.88	1.2%	(52,543)	7,020,816	5,721,334	22.7%
Physicians Health Plan of Greater St. Louis, Inc.	107.41	108.61	-1.1%	1,577,734	205,889,726	142,093,349	44.9%
*Principal Health Care of Kansas City, Inc.^	114.66	121.82	-5.9%	685,626	67,925,084	23,997,593	183.0%
Principal Health Care of St. Louis, Inc.	145.67	136.44	6.8%	2,476,918	53,619,520	46,201,014	16.1%
*Prudential Health Care Plan, Inc.	120.57	121.12	-0.5%	74,670,641	43,791,986	35,059,260	24.9%
Total Health Care	----	175.61	----	16,859,499	----	41,990,293	----
TriSource HealthCare, Inc., d/b/a Blue-Advantage	121.65	125.35	-2.9%	539,231	37,916,949	29,137,174	30.1%
ALL HMOs	**$118.62**	**$121.01**	**-2.0%**	**$146,867,851**	**$1,200,192,905**	**$1,038,613,537**	**15.6%**

Note: Data for companies in italics includes the experience of members residing in the state of Kansas.

*** Indicates administrative service only (ASO) member months have been excluded from the premium per member per month (PMPM) calculation.**

^ Indicates the data is calculated based on the Annual Statement Supplement filing data. All data elements, unless indicated otherwise, are based on the earned premium reported in the Premiums, Enrollment and Utilization Table in the Annual Statements.

Source: Missouri Department of Insurance

CME Calendar

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send CME information for free listing in *Missouri Medicine*.

DECEMBER

6 thru 8 - *St. Louis*: **Craniofacial Surgery.** 24 credit hours. Call Practical Anatomy Workshop 314-535-4000.

6 thru 8 - *Kansas City*: **Oncology in Primary Care: Controversies in Cancer Detection and Management.** Call CME office 573-882-0366.

7 - *St. Louis*: **Nursing Home Administrators Conference.** Call 1-800-553-2712.

7 - *St. Louis*: **Bipolar Mood Disorder in Clinical Practice.** 6.5 credit hours. Call Washington University School of Medicine 314-362-6891.

7 - *St. Louis*: **Contemporary Management of Congestive Heart Failure.** 3.5 credit hours. Call Washington University School of Medicine 314-362-6891.

9 - *St. Louis*: **MRI of Muscle and Tendon Injuries.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

12 thru 14 - *Kansas City*: **The Heart and Stroke in the 90's.** 18 credit hours. Call Kim McChesney 816-932-5140.

14 - *St. Louis*: **Nursing Home Administrators Conference.** Call 1-800-553-2712.

18 & 19 - *St. Louis*: **Doppler Echocardiography.** Call 1-800-553-2712.

JANUARY 1997

8 - *St. Louis*: **OB/GYN CPT/ICD-9 Coding Workshop.** Call 314-432-8712.

9 - *St. Louis*: **OB/GYN CPT/ICD-9 Coding Workshop.** Call 314-432-8712.

13 - *St. Louis*: **Applications of Breast Ultrasound.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

15 & 16 - *Kansas City*: **Palliative Care: What are the Choices?** 11 credit hours. Speakers: Drs. Alexander Peralta, Jr and Robert Enck. Call Barbara, Truman Medical Center 816-283-4519.

22 - *St. Louis*: **The Ninth Annual Joseph E. Flynn Lecture Series.** Call 314-569-6290.

27 thru 31 - *St. Louis*: **Medicolegal Death Investigators.** Call 1-800-553-2712.

FEBRUARY

10 - *St. Louis*: **New Insights into Costs and Motivations for Self Referral.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

15 - *St. Louis*: **Diabetes Update.** Call 1-800-553-2712.

21 - *St. Louis*: **OB/GYN CPT/ICD-9 Coding Workshop.** Call 314-432-8712.

27 - *St. Louis*: **OB/GYN CPT/ICD-9 Coding Workshop.** Call 314-432-8712.

MARCH

6 & 7 - *Kansas City*: **Hospice and End-Stage Dementia.** 9 credit hours. Speakers: Ladislav Volicer, MD, PhD. Call Barbara, Truman Medical Center 816-283-4519.

8 - *St. Louis*: **Hepatobiliary Disease.** Call 1-800-553-2712.

10 - *St. Louis*: **The Role of Nuclear Medicine in Assessment of Infections.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.

12 thru 14 - *St. Louis*: **The Tenth National Symposium Noninvasive Diagnosis of Vascular Disease.** Call 314-569-6290.

14 - *St. Louis*: **Bleeding Disorders.** Call 1-800-553-2712.

Continued on page 767

Classified Advertising

Position Wanted: Board Certified Internist with 14 years of practice experience, currently enrolled in a fellowship at a university learning procedural skills in cardiology, gastroenterology, and pulmonary medicine. Desires to relocate at the completion of training in the summer of 1997. Please address enquiries to C/O Position Wanted, Missouri Medicine, P.O. Box 1028, Jefferson City, MO 65102.

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Board Review-IM: Start early register for the Course, June 20-25, 1997, Columbus, Ohio, or Home study with text or video. Voice mail at 614-631-2756.

CME Calendar (continued)

21 & 22 - *St. Louis*: **Integrated Care of the Thoracic Surgery Patient. A Seminar for Allied Health Professionals.** Call Washington University School of Medicine 314-362-6891.

APRIL

11 - *St. Louis*: **Allergy for the Clinician.** Call 1-800-553-2712.
14 - *St. Louis*: **Leroy Sante Lecture.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology at 314-362-7130.
18 - *Lake Ozark*: **Mental Health and Aging.** Call 1-800-553-2712.
21 thru 25 - *St. Louis*: **Medicolegal Death Investigators.** Call 1-800-553-2712.
25 - *Branson*: **Update: Primary Care.** Call 1-800-553-2712.

MAY

12 - *St. Louis*: **Radiologic/Pathologic Correlates in Bronchogenic Carcinoma.** Call R. Gilbert Jost, MD, Malinckrodt Institute of Radiology at 314-362-7130.

JUNE

9 thru 11 - *St. Louis*: **Strengthening Instructional Skills.** Call 1-800-553-2712.
21 - *St. Louis*: **Summer Geriatrics Inst.** Call 1-800-553-2712.

JULY

28 thru 31 - *St. Louis*: **Masters Course: Death Investigators.** Call 1-800-553-2712.

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The reference should give name of author, title of article, name of periodical, year, volume number, and page numbers.

Example:
1. Galata JF, Blue JM, Gaines RW. Osteochondroma of the scapula. *Missouri Medicine* 1995;92:95-97.

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